

~BUPRENORPHINE ~
 Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of buprenorphine and Suboxone[®]. These criteria are based on concerns about safety and the potential for abuse and diversion. All requests must be submitted using this fax form.

Submit request via Fax (only): 1-866-767-2649

Prescribing physician:

 Name: _____
 Phone #: _____
 Fax #: _____
 Address: _____

Beneficiary:

 Name: _____
 Medicaid ID #: _____
 Date of Birth: _____ Sex: _____
 Diagnosis: _____

Contact Person at Office: _____

► Please answer the following questions:

Is buprenorphine being prescribed for opiate dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the prescriber signing this form have a DATA 2000 waiver ID number ("X-DEA license")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the prescriber queried the VPMS (Vermont Prescription Monitoring System) to review patient's scheduled II-IV medication history?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not signed up
A "Pharmacy Home" for ALL prescriptions has been selected AND discussed with patient? (Pharmacy must be located/licensed in VT) Pharmacy Name: _____ Pharmacy Phone #: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has patient filled a Suboxone RX in last 60 days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Request is for the following medication: Sublingual FILM	<input type="checkbox"/> Suboxone [®] (buprenorphine/naloxone)
Request is for the following medication: Sublingual TABLET	<input type="checkbox"/> Suboxone [®] (buprenorphine/naloxone) <input type="checkbox"/> Buprenorphine (formerly Subutex [®])
Anticipated maintenance dose/frequency: (target dose ≤ than 16 mg/day) (maximum 14 day supply per prescription fill) Dose: _____ Frequency: _____ (recommended once daily)	
If this request is for Buprenorphine (formerly Subutex [®]), please answer the following questions: Is the member pregnant? (please provide positive pregnancy test copy) If yes, anticipated date of delivery: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member breastfeeding a methadone or morphine dependent baby? (please provide history from neonatologist or pediatrician)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you have referred your patient to a methadone clinic if this option was conveniently located and available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional clinical information to support PA request:	

Prescriber Signature: _____ (stamps not acceptable)

Prescriber X-DEA License #: _____ **Date of request:** _____