



Department of Vermont Health Access
 312 Hurricane Lane, Suite 201
 Williston, Vermont 05495

BURPREN.1
 FORM#04
 C: 12.14

Agency of Human Services

~BUPRENORPHINE~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

Prescribing physician:

Beneficiary:

Name: _____
 Phone#: _____
 Fax#: _____
 Address: _____
 Contact Person at Office: _____

Name: _____
 Medicaid ID#: _____
 Date of Birth: _____ Sex: _____
 Pharmacy Name _____
 Pharmacy Phone: _____ Pharmacy Fax: _____

Anticipated maintenance dose/ frequency (target dose ≤ than 16 mg/day) (maximum 14 day supply per prescription fill)

	<u>Strength</u>	<u>Instructions</u>	<u>Dosage</u> <u>Quantity</u>	<u>Days Supply</u>	<u>Refills</u>
BUPRENORPHINE	_____	_____	_____	_____	1 2 3 4

Is buprenorphine being prescribed for opiate dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the prescriber query 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
Does the prescriber signing this form have a DATA 2000 waiver ID ("X-DEA license")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A "Pharmacy Home" for ALL prescriptions has been selected AND discussed with the 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 the last 60 days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
If this request is for Buprenorphine (formerly Subutex®), please answer the following questions: Is the member pregnant? (please provider 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 provider history from neonatologist or pediatrician)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete both pages of this PA request



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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
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Additional clinical information to support PA request:
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By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature: _____ **Date of request:** _____

