VERMONT

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

Agency of Human Services

~ OTP BUPRENORPHINE ~

Prior Authorization Form

All requests for Buprenorphine Mono or Buprenorphine/Naloxone outside of established clinical criteria must be reviewed and approved by the Substance Abuse Unit and the DVHA Medical Director. All requests must be submitted using this fax form.

Submit request via Fax (only): 1-802-871-3090

Prescribing physician:

Name: _____

Phone #: _____

Fax #: _____

Address: _____

Beneficiary:

Name: _____

Medicaid ID #: _____

Date of Birth: _____ Sex: _____

Diagnosis: _____

Contact Person at OTP: _____

► Please indicate if the request is for buprenorphine mono or Suboxone ® film and complete the required information.

☐ Buprenorphine (mono formulation) **DOSE PER DAY REQUESTED: _____MG**	☐ Pregnancy DUE DATE:_____ ☐ Intolerance to Suboxone ® film Description of intolerance:_____ _____

☐ Request is for Suboxone® (buprenorphine/naloxone) Sublingual **FILM** at > 16 mg/day.

DOSE PER DAY REQUESTED:_____MG

Results of last urine drug screen ☐ Negative ☐ Positive for:

☐Heroin ☐Opiates ☐Suboxone/Buprenorphine ☐Marijuana ☐Benzodiazepines

Date of Admission to OTP:_____

Withdrawal Assessment (COWS score):_____ Date of Assessment:_____

Other Substance Abuse Treatment received in the past year:

DRUG ABUSE ASSESSEMENT

DRUG	ROUTE	AMOUNT/FREQUENCY OF USE PRIOR TO ADMISSION
Heroin	☐ IV ☐ Smoke ☐ Nasal	
Prescription Opiates/Suboxone	☐ IV ☐ Smoke ☐ Nasal	
Cocaine	☐ IV ☐ Smoke ☐ Nasal	
Benzodiazepines		
Marijuana		
Alcohol		

Other Clinical Factors:

Prescriber Signature: _____ **(stamps not acceptable) Date of request:** _____

Last Updated 10/2013