



~BUPRENORPHINE ~

Prior Authorization Request Form (Spokes/OBOTS)

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety, sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare help desk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
 Name: _____
 Physician NPI: _____
 Specialty: _____
 Phone#: _____
 Fax#: _____
 Address: _____
 Contact Person at Office: _____

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

Dose: _____ Dosage Form (e.g. Film): _____ Frequency: _____ (recommended once daily)

A "Pharmacy Home" for ALL prescriptions MAY BE selected but is no longer required. Please indicate pharmacy you would like member to be locked in: (Optional) _____		
Is this a prior authorization renewal for a member stable on a MAT dose for greater than 1 year (If yes, please proceed to safety checklist on page 2. If no, please proceed with questions below.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For new requests exceeding dosage limits or quantity limits has documentation explaining medical necessity been included?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If this request is for a nonpreferred oral buprenorphine formulation, including mono buprenorphine (formerly Subutex®) , please answer the follow question:		
In your medical opinion, has the member experienced a current or past intolerance to the preferred products that cannot be resolved or mitigated through alternative efforts? *If Yes , please proceed to safety checklist on page two *If No , please provide clinical documentation explaining the need for nonpreferred formulation in addition to completing the safety checklist on page two	<input type="checkbox"/> Yes	<input type="checkbox"/> No
*If multiple doses are being requested to facilitate TITRATION, please indicated in clinical notes		
*Cutting films in half where clinically indicated at prescriber discretion is not prohibited by DVHA. However, it is recommended that this should be avoided, particularly if there are children in the home, as the child protection is then lost for the remainder of the dose. In addition, the manufacturer does not recommend splitting the film, and there is a lack of data on uniform potency.		

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.

Please document signature on page two



