Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~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: ___________

Anticipated maintenance dose/ frequency (target dose ≤ than 16 mg/day) (maximum 30-day supply per prescription fill)

Dose: _______________Dosage Form (e.g. Film):________Frequency :_______________(recommended once daily)

Is buprenorphine being prescribed for opiate dependency?	☐Yes ☐ No
Does the prescriber signing this form have a DATA 2000 waiver ID (“X-DEA license”)?	☐Yes ☐ No
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:
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: _____________ Duration of approval will be up to 1 month post anticipated due date.	☐Yes ☐ No
Is the member breastfeeding a methadone or morphine dependent baby? (please provider history from neonatologist or pediatrician) *Other requests will be considered after documented trial and failure of ALL oral Buprenorphine/Naloxone combination products.	☐Yes ☐ No
*Requests for non-preferred formulation(s) must include clinical documentation detailing a provider-observed reaction severe enough to require discontinuation. Documentation of measures tried to mitigate/manage symptoms is required. *Requests to exceed quantity limits or max daily dose must include documentation detailing medical necessity for requested dosing regimen. *If multiple doses are being requested to facilitate TITRATION, please indicate below:	

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:_________________________XDEA License#:_________________ Date of request:_____________

Last Updated: 1/2021