Reset Form Print Form

FLORIDA MEDICAID PRIOR AUTHORIZATION

Buprenorphine Agents for Opioid Dependence

Note: All relevant sections of the form must be completed in full.
An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

Complete this section for initiation and continuation: (**Refer to page 2 for required documents and the prescriber's signature)**

PREFERRED AGENTS WITH CLINICAL PRIOR AUTHORIZATION: BUPRENORPHINE SUBLINGUAL TABLETS, BUPRENORPHINE/NALOXONE SUBLINGUAL TABLETS, SUBOXONE® FILM AND ZUBSOLV® SUBLINGUAL TABLETS.

Name of requested medication: _____ Dose: _____ Directions: _____

Check one: ☐ Induction ☐ Stabilization ☐ Maintenance **Induction date** (required): _____

Anticipated length of therapy: _____

1) Is the patient pregnant or nursing? ☐ Yes ☐ No
   - Expected date of delivery: _____
2) Is this request for the treatment of opioid dependence? ☐ Yes ☐ No
3) Is this request for the treatment of pain? ☐ Yes ☐ No
4) Is the patient taking other opioids, tramadol or carisoprodol? ☐ Yes ☐ No
5) Is the prescriber registered to prescribe buprenorphine under the Substance Abuse and Mental Health Services Administration (SAMHSA)? ☐ Yes ☐ No

Initiation of Therapy or Initial Medicaid Review: (Supporting documentation is required for answers to all the questions)

1) Does the patient have a confirmed DSM V diagnosis of opioid disorder? ☐ Yes ☐ No
2) Has an initial drug screen been performed to verify presence of opiates and other substances? ☐ Yes ☐ No
3) Has the patient failed more than one prior attempt with opiate agonist treatment within the past 12 months?
   ☐ Yes ☐ No If *YES*, provide date(s) of relapse(s): _____
4) Does the patient have co-morbid conditions that would interfere with compliance? ☐ Yes ☐ No
   List: _____
5) What best describes the recovery environment for this patient? ☐ Supportive ☐ Unsupportive ☐ Toxic
6) Has the patient been referred to a support group or licensed mental health counselor for psychological counseling?
   ☐ Yes ☐ No If *YES*, specify: _____
7) Has the patient been referred for a psychiatric evaluation if indicated? ☐ Yes ☐ No
8) Has the patient signed a contract (attach) and committed to both pharmacologic and non-pharmacologic modalities of treatment? ☐ Yes ☐ No

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Continuation of therapy: (Supporting documentation is required for answers to all the questions)

1) Is the patient compliant with pharmacologic therapy? ☐ Yes ☐ No
   - Drug screen (attach) date: _____
2) Is the patient compliant with non-pharmacologic therapy? ☐ Yes ☐ No
   - Provide details (support type [group or individual], frequency of attendance, dates)
     _____
     _____
3) How long has the patient been stable at the current dose? _____
4) Is the patient ready to taper the dose at this time? ☐ Yes ☐ No
   - If no, provide rationale: _____
     _____
   - If yes, provide taper schedule: _____
5) Is the revised individualized treatment plan reflecting follow-up at the most current office visit attached for review?
   ☐ Yes ☐ No

Date of next office visit: _____

Prior Authorization Standards for Review:

Medicaid prior authorization review is intended for office-based treatment of opioid dependency for individuals who meet the following criteria:

- With an adequate amount of psychosocial support; family/peers
- With a readiness for change and a personal commitment to live a drug-free lifestyle
- With a willingness to comply with all elements of the treatment plan, including pharmacologic and non-pharmacologic aspects of the established protocol
- With consistent regular drug screens that are negative for opiates
- With a willingness to abstain from illicit drugs

Helpful Links:

- Medicaid resources the SAMHSA recommendations: http://www.samhsa.gov/
- National Library of Medicine for *Clinical Guidelines for Use of Buprenorphine in the Treatment of Opioid Addiction:* http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A72248

Prescriber's Signature: _____ **Date:** _____

SAMHSA DEA#: _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to:
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

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