



Request for Prior Authorization
Buprenorphine/Naloxone

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Prior authorization is required for buprenorphine or buprenorphine/naloxone. Requests for doses above 24 mg per day or greater than once daily dosing will not be considered.

- 1) Patient has a diagnosis of opioid dependence and is 16 years of age or older; AND
2) Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has an "X" DEA number; AND
3) Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy; AND
4) A projected treatment plan is provided with initial request (see below requirements).
5) Requests for renewal must include updated treatment plan and additional documentation as indicated below.
6) Requests for buprenorphine will only be considered for pregnant patients.

Preferred

Suboxone SL Film

Non-Preferred

- Buprenorphine (Please verify patient is pregnant) No Yes
Buprenorphine/Naloxone SL Tabs
Zubsolv

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Prescriber meets qualifications to prescribe and treat opioid dependence and possess "X" DEA number:

No Yes

Patient participates in and is compliant with counseling: No Yes

Date of most recent counseling session:

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**Initial Requests:** Include projected treatment plan. May attach treatment plan or provide at a minimum the below information:

- Anticipated induction/stabilization dose: \_\_\_\_\_
- Anticipated maintenance dose: \_\_\_\_\_
- Expected frequency of office visits: \_\_\_\_\_
- Expected frequency of counseling/psychosocial therapy visits: \_\_\_\_\_

**Renewal Requests:** Please provide the below information:

- Updated treatment plan, including consideration of a medical taper to the lowest effective dose based on a self assessment scale. Date of most recent taper attempt: \_\_\_\_\_
- Documentation the Iowa Prescription Monitoring Program (PMP) website has been reviewed for the patient's use of controlled substances since the last prior authorization request.  No  Yes  
Date reviewed: \_\_\_\_\_
- Documentation of a current, negative drug screen. Date of most recent drug screen: \_\_\_\_\_
- Documentation the patient has been compliant with office visits and counseling/psychosocial therapy visits.  
Compliant with office visits?  No  Yes  
Date of most recent office visit: \_\_\_\_\_

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.