Save Form | Print Form | Reset Form

FLORIDA MEDICAID

PRIOR AUTHORIZATION

Buprenorphine Agents

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 License # (ME, OS, ARNP, PA)

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)**

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 diagnosis of opioid dependency? ○ 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

Date of next office visit: _____

Continued on page 2. Both pages of the Buprenorphine Agents prior authorization form must be submitted for review.

FLORIDA MEDICAID

PRIOR AUTHORIZATION

Buprenorphine Agents

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

Recipient's Full Name

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

1) Is the patient compliant with pharmacologic therapy? ○ Yes ○ No
   - o Drug screen (attach) date: _____
2) Is the patient compliant with non-pharmacologic therapy? ○ Yes ○ No
   - o 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
   - o If no, provide rationale: _____
   - o 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: _____ SAMHSA DEA# _____ DATE: _____

***Required for review*: Medical records including the clinical evaluation, the individualized recovery treatment plan, progress notes, random drug screens and a copy of the original prescription. Additional documentation may also be required to support the request.**

The provider must retain copies of all documentation for five years.

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727