

Alaska Medicaid Suboxone®/Buprenorphine Prior Authorization Form

Prescriber Use Only

Fax this request to: 1-888-603-7696

Questions: Call Magellan Medicaid Administration at 800-331-4475

Or mail this request to: Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043

Note: This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before submitting this form. 06/2015

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Form available at: <http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>

Requestor: Must be requested by prescriber and by fax only. See below.

Member

Last Name	First Name	Initial
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth	Member ID	Sex
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female

Prescriber

Name	NPI
<input type="text"/>	<input type="text"/>
Phone: <input type="text"/> - <input type="text"/> - <input type="text"/>	Fax: <input type="text"/> - <input type="text"/> - <input type="text"/>

Specialty: _____

Request

Doses > 3 units per day **OR** 24 mg per day will **NOT** be approved. Only 1 strength of 1 product will be authorized for use at a given time.

Check only one box below:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bunavail® 2.1mg–0.3mg film | <input type="checkbox"/> Bunavail® 4.2mg–0.7mg film | <input type="checkbox"/> Bunavail® 6.3mg–1mg film |
| <input type="checkbox"/> Suboxone® sublingual film 2mg–0.5mg | <input type="checkbox"/> Suboxone® sublingual film 4mg–1mg | <input type="checkbox"/> Suboxone® sublingual film 8mg–2mg |
| <input type="checkbox"/> Suboxone® sublingual film 12mg–3mg | | |
| <input type="checkbox"/> Zubsolv® 0.7mg–0.18mg SL tablet | <input type="checkbox"/> Zubsolv® 1.4mg–0.36mg SL tablet | <input type="checkbox"/> Zubsolv® 2.9mg–0.71mg SL tablet |
| <input type="checkbox"/> Zubsolv® 5.7mg–1.4mg SL tablet | <input type="checkbox"/> Zubsolv® 8.6mg–2.1mg SL tablet | <input type="checkbox"/> Zubsolv® 11.4mg–2.9mg SL tablet |
| <input type="checkbox"/> Buprenorphine/Naloxone 2mg–0.5mg SL tablet | <input type="checkbox"/> Buprenorphine/Naloxone 8mg-2mg SL tablet | |
| <input type="checkbox"/> Buprenorphine/Naloxone 8mg–2mg SL film | <input type="checkbox"/> Buprenorphine SL 8mg tablet | <input type="checkbox"/> Buprenorphine SL 2mg tablet |

Quantity: _____ **Sig:** _____

Rationale for Prior Authorization

PA Start Date: / /

Primary Diagnosis: ICD-10: _____

Check all that apply:

- The patient is at least 16 years old.
- The patient is being treated for opioid dependence and has agreed to adhere to a treatment plan.
- The physician meets all qualifications (State and Federal) to prescribe buprenorphine products for treatment of opioid addiction.
- The physician has explained the risks of using buprenorphine products with benzodiazepines, alcohol, tranquilizers and narcotic analgesics to the patient.

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

Prescriber's Data 2000 Waiver DEA#:** _____

**Drug Addiction Act of 2000

***** All sections must be completed or the request will not be approved*****

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