

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

BUTRANS (buprenorphine)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992**

CRITERIA:

- Minimum age requirement: 18 years old.
- Diagnosis of moderate to severe chronic pain requiring continuous, around-the-clock opioid analgesic for an extended period of time.
- Documented trial and failure of ≥ 1 oral non-opioid agent(s).
- Documented trial and failure of ≥ 1 oral opioid agent(s).

NOTES:

- Prior Authorization will be granted for up to 4 patches per 28 days. Additional quantities may be granted with satisfactory prescriber explanation during the first and last months of therapy to allow for dose titration.

AUTHORIZATION:

Initial authorization period is for 3 months.

RE-AUTHORIZATION:

Reauthorization periods of up to one year require documentation that the patient is using the drug appropriately, and documentation of satisfactory pain control faxed to 855-828-4992.

10/03/2016

<https://medicaid.utah.gov/pharmacy/>