

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**LONG ACTING OPIATES**  
**(see separate criteria for Methadone)**

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_

Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

Requested Medication: \_\_\_\_\_ Pharmacy NPI#: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

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

---

**FAX A LETTER OF MEDICAL NECESSITY TO 855-828-4992**

**Prior authorization is NOT required in the following instances:**

- Member is  $\geq$  18 years old; AND
- Member has used a short-acting opiate, including tramadol or tapentadol, within the past 30 days (i.e. opiate tolerant); AND
- Member does not have a paid claim for a benzodiazepine within the past 45 days; AND
- Member does not have a paid claim for any buprenorphine-naloxone combination, buprenorphine, naloxone or naltrexone medication within the past 18 months

**Prior authorization IS required in the following instances:**

- Member is  $<$  18 years old; OR
- Member has not used a short-acting opiate, including tramadol or tapentadol, within the past 30 days (i.e. opiate tolerant); OR
- Member has a paid claim for a benzodiazepine within the past 45 days; OR
- Member has a paid claim for any buprenorphine-naloxone combination, buprenorphine, naloxone or naltrexone medication within the past 18 months.

Include a treatment agreement, including discontinuation criteria, signed by the provider and the member.

**Note:**

If the member is enrolled in a research protocol or clinical trial involving the long acting opiate, the trial must provide the medication.

**Initial Authorization:** 6 months

**Reauthorization:** 6 months