

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

METHADONE
(see separate criteria for Long Acting Opiates)

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

Member Criteria:

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

Prescriber Criteria:

- Include a treatment agreement, including discontinuation criteria, signed by the provider and the member.
- Prescriber must hold and provide copy of a current American Board of Medical Specialties (ABMS) Pain Medicine Subspecialty Certificate or equivalent training OR must work in continued consultation with a prescriber that holds a current ABMS Pain Medicine Subspecialty Certificate.

All Member Criteria and Prescriber Criteria must be met for the request to be considered.

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: 3 months

Reauthorization: 6 months