UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Oral Buprenorphine & Buprenorphine/ Naloxone Products

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Preferred Products	Daily Dose Limit	Daily Quantity Limit
buprenorphine tablet	24mg	3 sublingual tablets
buprenorphine/naloxone tablet	24mg	3 sublingual tablets
Suboxone film	24mg	3 sublingual films

Non-Preferred Products	Daily Dose Limit	Daily Quantity Limit
buprenorphine/naloxone film	24mg	3 sublingual films
Zubsolv	17.1 mg - 4.2 mg	2 sublingual tablets

Criteria for Exceeding Quantity Limit and Non-Preferred Product: (Must be met for *All* requests):

1. Does the patient have a diagnosis of Opioid Use Disorder (OUD)? ❑ **Yes** ❑ **No**

Additional Criteria for Exceeding Quantity Limit: (At least *ONE* of the following criteria must be met)

2. Is the patient pregnant? ? ❑ **Yes** ❑ **No**
   Estimated delivery date: _____
3. Is the patient a rapid drug metabolizer previously identified by genetic testing? ❑ **Yes** ❑ **No**
4. Is the patient on OUD treatment with CYP3A4 inducers, affecting medication metabolism? ❑ **Yes** ❑ **No**
5. Is the patient starting the induction phase for a single-agent buprenorphine product? *(approval up to 14 days)* ❑ **Yes** ❑ **No**
6. Does the patient have temporary acute pain management during OUD treatment? *(approval up to 14 days)* ❑ **Yes** ❑ **No**
7. Has the patient had an inadequate response to treatment within dose and/or qty limits and is at risk for relapse? Duration requested: _____ ❑ **Yes** ❑ **No**

Additional Criteria for Non-Preferred Product (*All* of the above criteria must also be met)

8. Has the patient tried and failed a preferred product in the same PDL class? ❑ **Yes** ❑ **No**
   Medication: _____ Details of failure: _____
9. Has the prescriber demonstrated medical necessity for a non-preferred product? ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the patient had clinically significant improvement as shown by the specific appropriate monitoring parameters and/or improvement in symptoms? Chart note page #: _____ ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year. No reauthorization for temporary pain management.

Note:

- Utah Medicaid aligned with the American Society of Addiction Medicine National Practice 2020 guidelines to recommend psychosocial treatment in conjunction with medications for the treatment of, or prevention of relapse to opioid use disorder

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date