State of Maine Department of Health & Human Services

MaineCare/MEDEL Prior Authorization Form

Buprenorphine/Naloxone & Mono-Product Buprenorphine Prior Authorization Form

Phone: 1-888-445-0497 **ONE Drug Per Form ONLY – Use Black or Blue Ink** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| Patient Name: ___________________________________ DOB: __________________
(NOT MEDICARE NUMBER)
Patient Address:____

Provider X DEA: |__|__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:____ Phone:___________________

Provider Address:____ Fax:___________________

Pharmacy (Rx) Name:_________________________Rx Address:_______________________________Rx phone:________________

***** NOTE: Providers must complete this Prior Authorization (PA) form when requesting any of the following:***

1. Any buprenorphine dose greater than 24mg/day
2. Buprenorphine dose greater than 16mg and up to 24 mg/day for more than 30 days
3. Early refills requested for travel, or for lost or stolen medication
4. Use of buprenorphine monotherapy in cases other than pregnancy, or for doses above 16mg/d

Buprenorphine/Naloxone PA Request	**Strength**	**Dosage Instructions**	**Total Daily Dose**	**Quantity**	**Days Supply (34D max retail)**
☐ Buprenorphine/ naloxone tabs (Suboxone) films					
☐ Buprenorphine/ naloxone tabs					

Please provide clinical indication *(check indication and/or provide additional supporting clinical information):*

☐ Patient is at high risk for recurrence of use and/or has documented return to drug use while on 16 mg/day
☐ Patient is pregnant and has demonstrated need for greater than 16mg/d (e.g. increased cravings, risks, or use)
☐ Early refill required for ☐ anticipated patient travel or ☐ lost or stolen medication
☐ Other (*please describe):* ____

Mono-product buprenorphine PA Request	**Strength**	**Dosage Instructions**	**Total Daily Dose**	**Quantity**	**Days Supply** (34D max retail)
☐ Buprenorphine tabs					

Please provide clinical indication (NOTE: PA *not* required for use of mono-product in pregnancy up to 16mg/d):

☐ Patient has demonstrated evidence of true allergic reaction (e.g. rash, shortness of breath, anaphylaxis) (*Note*: other complaints such as bad taste, mouth tingling, etc. do not constitute evidence of allergy)
☐ Patient is pregnant and has demonstrated need for greater than 16mg/d (e.g. increased cravings, risks, or use)
☐ Other (*please describe):* ____

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care; such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member, and is supported in your medical records.

Provider Signature*: ____ Date of Submission: ________
***MUST MATCH PROVIDER LISTED ABOVE**

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***NOTE:** If a **Non-Preferred** formulation of buprenorphine/naloxone (e.g. Zubsolv tabs or Bunavail films) or if extended-release buprenorphine (e.g. Sublocade, Probuphine) is being requested, please complete a **MaineCare Prior Authorization Form 20420.**

For **complete coverage criteria,** please refer to the MaineCare Preferred Drug List at www.mainecarepdl.org