NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION
BUPRENORPHINE/NALOXONE AND BUPRENORPHINE

(NOTE: Prior authorization is NOT required for Preferred Agents in this class. Refer to the current PDL at **https://nebraska.fhsc.com/PDL/PDLlistings.asp** to see the Preferred Agents for Opiate Dependence Treatments

PRESCRIBING PHYSICIAN:

Name: _____
First Last

Phone #: ☐☐☐-☐☐☐-☐☐☐☐

Fax #: ☐☐☐-☐☐☐-☐☐☐☐

NPI ☐☐☐☐☐☐☐☐☐☐

DEA X ☐☐ ☐☐☐☐☐☐☐

DEA X# Exp ☐☐/☐☐/☐☐☐☐

MEDICAID RECIPIENT:

Name: _____
First Last

Medicaid #: ☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

(NOTE: Patient must be 16 years or older.)

☐ **Male** ☐ **Female**

PARTICIPATING PHARMACY:

Name: _____

Request Date: _____

Phone #: ☐☐☐-☐☐☐-☐☐☐☐

Fax #: ☐☐☐-☐☐☐-☐☐☐☐

Buprenorphine/ Naloxone film Buprenorphine/Naloxone tablet Buprenorphine tablet (circle one)	**Strength:**	**Qty Per Day:**	**Maximum Duration of Prior Authorization** **12 months**
Diagnosis confirmed as treatment of Opioid Use Disorder and not pain management: ☐ Yes ☐ No			
****ABOVE PRODUCTS ARE NOT COVERED FOR PAIN MANAGEMENT****			

☐ INITIAL REQUEST ☐ RENEWAL REQUEST

1) Has the patient failed treatment with the preferred product?	☐ Yes ☐ No
2) Prescriber has been issued an "X" DEA license number to prescribe?	☐ Yes ☐ No
3) Does the patient have other opioid (including tramadol) or benzodiazepine medications prescribed at time of buprenorphine initiation? (must be discontinued for authorization)	☐ Yes ☐ No
4) Has the patient signed a contract (*or Informed Consent*)? (attach either clinic standard form or Nebraska form)	☐ Yes ☐ No
5) Is the patient pregnant or nursing? Expected delivery date _____)	☐ Yes ☐ No
6) For renewal: Has patient been compliant with contract (*or Informed Consent*) and had appropriate random urine drug screening results?	☐ Yes ☐ No

Submit requests to: Magellan Medicaid Administration, Inc. **Fax: 1-866-759-4115**
Tel: 1-800-241-8335