Nebraska Medicaid Program

Request for Prior Authorization

For Opioid-Dependence Treatment

Fax this form to 866-759-4115

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 opioid-dependence treatments.

MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____

Medicaid ID: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female (Note: Patient must be 16 years of age or older.)

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber NPI: _____

PARTICIPATING PHARMACY

Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

DRUG INFORMATION

**** Products Are Not Covered For Pain Management****

Drug Name: _____ NDC: _____

Drug Strength: _____ Dosing Frequency: _____

Quantity: _____ Maximum Duration of Prior Authorization: 12 months

☐ New Therapy ☐ Renewal

If Renewal, date therapy initiated: _____

Member's Name: _____

CLINICAL INFORMATION

1. Is the patient's diagnosis confirmed as treatment of Opioid Use Disorder, NOT pain management?

   ☐ Yes ☐ No

2. Has the patient failed treatment with the preferred product?

   ☐ 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 statement? (Attach either clinic standard form or Nebraska form.)

   ☐ Yes ☐ No

5. Is the patient pregnant or nursing?

   ☐ Yes ☐ No

   If Yes, expected delivery date: _____

6. For renewal: Has the patient been compliant with their contract (or informed consent) and had appropriate random urine drug screening results?

   ☐ Yes ☐ No

I certify that the indicated treatment is medically necessary, and all information is true and correct to the best of my knowledge. I also attest that I have obtained authorization to release the above information. I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

(required)

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.) Please note: The department may request chart documentation to verify the above information.

Fax this form to 866-759-4115

or mail to

Prime Therapeutics State Government Solutions LLC, MAP Dept.
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Tel: 1-800-241-8335