Kentucky Medicaid Substance Use Treatment Pharmacy Prior Authorization Form
For Buprenorphine Products

- **Buprenorphine Product prior authorizations for substance use treatment can ONLY be requested by AUTHORIZED PHYSICIANS using This Form.**
- **For Pain Management - Please use the Kentucky Medicaid Pharmacy Prior Authorization Form (only limited buprenorphine products are approved for pain management).**

Length of authorization: Initial Request: Two (2) months; Maintenance Request: Six (6) months

Complete each section legibly and completely. Include any supporting documents as needed (lab results, chart notes, etc.).

Please fax completed form to the corresponding fax number of the health plan partner your patient is currently enrolled. Additional prior authorization forms can be found by clicking on hyperlinks provided to the right.

Plan:	Phone number:	Fax number:
☐ Fee-For-Service (Magellan)	1 (800) 477-3071	1 (800) 365-8835
☐ Anthem Medicaid	1 (855) 661-2028	1 (844) 879-2961
☐ Aetna Better Health	1 (855) 300-5528	1 (855) 799-2550
☐ Humana	1 (800) 555-2546	1 (877) 486-2621
☐ Passport Health Plan	1 (844) 380-8831	1 (844) 802-1406
☐ WellCare of Kentucky	1 (877) 389-9457	1 (855) 620-1868

I. Member Information

Member Name:	Date of Birth:
Member ID:	Sex: ☐ Male ☐ Female
Address: City, State, Zip:	Phone:

II. Prescriber Information

Name:	DEA:
Office Contact Name: Office Address: City, State, Zip: Phone:	**XDEA**: NPI: FAX:

1. Prescriber is enrolled as a valid Medicaid prescriber? ☐ Yes ☐ No
2. Prescriber certifies they are treating the patient for a substance use disorder and billing Medicaid for such service(s) through the member's health plan? ☐ Yes ☐ No
3. Prescriber is compliant with all stipulations in the practice act regulation **(201 KAR 9:270)** when dispensing buprenorphine products? ☐ Yes ☐ No

III. Diagnosis Criteria

Diagnosis:	**ICD-10 Code:**

1. Patient has signed an informed consent or treatment contract? ☐ Yes ☐ No
2. Prescriber has explained treatment alternatives and the risks and benefits of using buprenorphine and buprenorphine containing products to the patient, along with the risk of using these products with alcohol, stimulants, other opioids, or benzodiazepines? ☐ Yes ☐ No

Other Relevant Diagnoses:

IV. REQUESTED BUPRENORPHINE SINGLE INGREDIENT PRODUCT

Medication Requested:		
Directions for Use:		
Dosage Strength Requested:	Quantity:	Total mg Per Day:
Day Supply:	Duration of Therapy:	

Female Patients Only:

1. Is the patient pregnant or nursing? ☐ Yes ☐ No
   If **YES**, prescriber must be certified in addiction medicine, psychiatry, obstetrics, or maternal-fetal medicine by the American Board of Addiction Medicine (ABAM), the American Board of Medical Specialties (ABMS), or an American Osteopathic Association (AOA) certifying board **AND** document consultation with a second certified provider.
2. Has patient been counseled on the risk of neonatal abstinence syndrome? ☐ Yes ☐ No
   Required for Review: Documentation of recent pregnancy test or inability to conceive and/or documentation of counseling as to the risk of neonatal abstinence syndrome by a certified prescriber.
3. If applicable, has the patient been offered means to prevent pregnancy? ☐ Yes ☐ No

REQUIRED EXPLANATION (if applicable, please submit documentation of pregnancy or naloxone hypersensitivity reaction):
Check One: ☐ Patient pregnant and/or breastfeeding ☐ Induction Protocol ☐ Naloxone hypersensitivity ☐ Implant or injectable

V. REQUESTED BUPRENORPHINE-NALOXONE PRODUCT		
Medication Requested:		
Directions for Use:		
Dosage Strength Requested:	Quantity:	Total mg Per Day:
Day Supply:	Duration of Therapy:	

Please indicate whether this is a/an: ☐ **INITIAL Request** ☐ **REAUTHORIZATION (REFILL) Request (with current plan)**

VI. INITIAL TREATMENT REQUESTS ONLY (**if request is for continuation therapy skip to Section VII**)

1. Has the prescriber identified (through KASPER, patient history, etc.) use of any benzodiazepines, sedative hypnotics, stimulants or other opioids within the past (14) days prior to the request? ☐ Yes ☐ No If yes, have they been discontinued? ☐ Yes ☐ No
   If no, please refer to criteria for documentation that must be submitted for approval. For concomitant use, the prescriber must be certified through the American Board of Addiction Medicine (ABAM), the American Board of Medical Specialties (ABMS) in psychiatry, the American Osteopathic Association (AOA) certifying board in addiction medicine or psychiatry, **OR** if not, they have consulted with such a certified practitioner. Please document your specialty or the name and specialty of consulted prescriber or document acute medical need and days' supply of less than or equal to thirty (30) days.
2. Prescriber has provided documentation (e.g., chart notes) of the initial assessment and monitoring plan in accordance with **(201 KAR 9:270)**? ☐ Yes ☐ No
3. Prescriber has obtained the KASPER report no earlier than two (2) days prior to the date of this request? ☐ Yes ☐ No

KASPER Request Number:	Date Last Queried:	Number of Concomitant Narcotic Prescriptions:	Date of Last Controlled Substance Filled:

Initial KASPER should include controlled substance fill history for the twelve (12) months from the date KASPER report was obtained.

VII. REAUTHORIZATION (REFILL) REQUESTS ONLY (with current plan)

1. The prescriber has included documentation (e.g., chart notes) that includes an evaluation of patient's dosage and/or clinical reasoning for continuing buprenorphine therapy? ☐ Yes ☐ No (dose evaluations are required every three (3) months after initiation)
2. Prescriber has obtained the KASPER report at least once in the last three (3) months? ☐ Yes ☐ No

Required for Review: Documentation of all monitoring, lab tests and drug screens including medication compliance checks since previous authorization. Drug screen shall include a minimum of buprenorphine, methadone, opioids, THC, benzodiazepines, stimulants, and cocaine. A minimum of eight (8) drug screens must be obtained from the patient within each twelve (12) month period of treatment and at least two (2) of the drug screens shall be random and coupled with a pill count.

Current dose – patient's current buprenorphine milligram (mg) daily dose is: _____ mg daily

Dose evaluation (every twelve (12) months) – must be completed if dose is greater than 16 mg daily:

Is prescriber certified through the American Board of Addiction Medicine (ABAM), the American Board of Medical Specialties (ABMS) in psychiatry, or the American Osteopathic Association (AOA) certifying board in addiction medicine or psychiatry? ☐ Yes ☐ No

If no, has prescriber referred patient to such a certified prescriber? ☐ Yes ☐ No

Please document the name and specialty of consulted prescriber or document acute medical need and day supply of less than or equal to thirty (30) days. If both no, request must be denied.

Other Pertinent Information: **(attach additional pages if needed)** _____

_____

I attest, by signature, that the above information is true and accurate to the best of my knowledge and has been documented appropriately in the patient's medical records.

Prescriber Printed Name and Signature:	Date: