

FAX completed form to  
Goold Health Systems (GHS)  
1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program  
PRIOR AUTHORIZATION REQUEST FORM

PHONE:  
(For questions or inquiries ONLY)  
1-877-207-1126

**Oral buprenorphine/naloxone or oral buprenorphine**

Provider must fill in all information below. It must be legible, correct and complete or the form will be returned.

Client ID #: \_\_\_\_\_

Client's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Prescriber NPI: \_\_\_\_\_

Prescriber XDEA (Required): \_\_\_\_\_

Prescriber's Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Pharmacy NPI: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

| <u>Drug Name</u> (Only one drug per form) | <u>Strength</u> | <u>Dosage Instructions</u> | <u>Days Supply</u> | <u>Quantity</u> | <u>Refills</u> |
|---|-----------------|----------------------------|--------------------|-----------------|----------------|
|---|-----------------|----------------------------|--------------------|-----------------|----------------|

1. Is this only a dose or quantity change from a previously approved PA?  Yes  No
2. Can the previously approved PA be cancelled?  Yes  No
3. Client's medical diagnosis \_\_\_\_\_
4. Is this client currently being treated with oral buprenorphine/naloxone or oral buprenorphine? Yes  No
5. If yes, when was the treatment initiated? \_\_\_\_\_

**Oral buprenorphine/naloxone or oral buprenorphine criteria**

- The client must have diagnosis of opioid dependence or abuse. These medications will not be covered for the treatment of chronic pain.
- The client will be limited to a maximum daily dosage of 16mg/day for the first two years of treatment. After two years of treatment the client will be limited to a maximum daily dosage of 8mg/day.
- The client will NOT be allowed to fill any narcotic prescription between oral buprenorphine/naloxone or oral buprenorphine fills without prior authorization.
- Oral buprenorphine will only be approved for clients that are pregnant, nursing, or have a documented allergy to oral naloxone.
- Please note that during the first two years of treatment, for any further approvals past six (6) months or for dose changes, the status of the client's progress, tapering schedule and treatment plan will be required.
- ❖ To request a client's Control Substance (II-IV) profile please refer to the Wyoming Online Prescription Database (WORx) at <http://worxpdp.com/account/login>.
- ❖ For more information regarding the Wyoming Medicaid Pharmacy Lock-in Program, which limits certain Medicaid clients to receiving prescription services from a single designated pharmacy provider, please contact the Medicaid Pharmacy Case Manager at 307-777-8773.

Prescriber Signature: \_\_\_\_\_ Date(s) of Submission: \_\_\_\_\_

\*MUST MATCH PRESCRIBER LISTED ABOVE