FAX completed form to
Change Healthcare
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: _____

Drug Name (Only one drug per form)	**Strength**	**Dosage Instructions**	**Days Supply**	**Quantity**	**Refills**

1. Is this <u>only</u> 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? _____

<u>Oral buprenorphine/naloxone or oral buprenorphine criteria</u>

- The client must have ***<u>diagnosis of opioid dependence or abuse</u>***. These medications will not be covered for the treatment of chronic pain.
- The client will be limited to a ***<u>maximum daily dosage of 16mg/day for the first two years of treatment</u>***. After two years of treatment the client will be limited to a ***<u>maximum daily dosage of 8mg/day</u>***.
- The client will ***<u>NOT be allowed to fill any narcotic prescription between oral buprenorphine/naloxone or oral buprenorphine fills without prior authorization</u>***.
- Oral buprenorphine will only be approved for clients that are ***<u>pregnant, nursing, or have a documented allergy to oral naloxone</u>***.
- Please note that during the first two years of treatment, for any further approvals past six (6) months or for dose changes, ***<u>the status of the client's progress, tapering schedule and treatment plan will be required</u>***.

- **To request a client's Control Substance (II-IV) profile please refer to the Wyoming Online Prescription Database (WORx) at http://worxpdmp.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: _____

**** Prescriber's original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.***