

FAX completed form to
Change Healthcare
1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program
PRIOR AUTHORIZATION REQUEST FORM
Oral buprenorphine/naloxone or oral buprenorphine

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

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
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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 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://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.