

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'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>
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|---|------------------------------|-----------------------------|
| 1. Is this <u>only</u> a dose or quantity change from a previously approved PA? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Can the previously approved PA be cancelled? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 24mg/day. Prior authorization will be required for doses >24mg/day with clinical justification.
- 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.

- ❖ To request a client's Control Substance (II-IV) profile please refer to the AWARe WY Prescription Drug Monitoring Program at <https://wyoming.pmpaware.net>.
- ❖ 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: _____

* By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.