

MAT therapy - Medication Assisted Treatment - Ohio Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.**

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

BUPRENORPHINE SUBLINGUAL TABLET

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented intolerance to naloxone?
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<input type="checkbox"/> Yes <input type="checkbox"/> No	If female, is the patient pregnant or breast-feeding?
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OPIOID DEPENDENCE IN PATIENTS LESS THAN 16 YEARS OF AGE

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the prescriber attest awareness of Food and Drug Administration (FDA) labeling regarding use of Medication Assisted Treatment agents (e.g. Suboxone, buprenorphine, buprenorphine/naloxone, Bunavail, Zubsolv) in patients less than 16 years of age?
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the prescriber attest that Medication Assisted Treatment (MAT) is medically necessary?
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Provide documentation of clinical rationale supporting use of MAT agents:
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QUANTITY LIMIT

<input type="checkbox"/> Yes <input type="checkbox"/> No	Provide clinical rationale of need to exceed the buprenorphine daily limit of 16 or 24 milligrams (mg):
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Provider Signature: _____ **Date:** _____

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