NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION BUPRENORPHINE/NALOXONE AND BUPRENORPHINE

PRESCRIBING PHYSICIAN:

Name: ______________________________

First Last

Phone #: (_____)-_______-_______

Fax #: (_____)-_______-_______

NPI #: ______________________________

DEA #: ______________________________

MEDICAID RECIPIENT:

Name: ______________________________

First Last

Medicaid # □□□□□□□□□□□

Date of Birth: □□/□□/□□□□

(Note: patient must be 16 years or older).

Male **Female**

PARTICIPATING PHARMACY:

Name: ______________________________

Phone #: (_____)-_______-_______

Request Date: ________________________

Fax #: (_____)-_______-_______

	Strength:	**Qty Per Day:**	**Maximum Duration of Prior Authorization**
Buprenorphine/ Naloxone film Buprenorphine/Naloxone tablet Buprenorphine tablet			**12 months**
Diagnosis confirmed as treatment of Opioid Use Disorder and not pain management:			Yes No
****ABOVE PRODUCTS ARE NOT COVERED FOR PAIN MANAGEMENT****			

INITIAL REQUEST RENEWAL REQUEST

1. Prescriber has been issued an "X" DEA license number to prescribe? □Yes □ No

2. Does the patient have other opioid (including tramadol) or benzodiazepine medications prescribed at time of buprenorphine initiation? (must be discontinued for authorization) □Yes □ No

3. Has the patient signed a contract (*or Informed Consent*)? (attach either clinic standard form or Nebraska form) □Yes □ No

4. Is the patient pregnant or nursing? □Yes □ No
Expected delivery date ________________

5. For renewal: Has patient been compliant with contract (or Informed Consent) and had appropriate random urine drug screening results □Yes □ No

Submit request to: Envolve Pharmacy Solutions Fax: 1-866-399-0929 Tel: 1-844-330-7852