State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
Suboxone/Buprenorphine Authorization

Phone: 1-888-445-0497 **ONE Drug Per Form ONLY – Use Black or Blue Ink** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider X DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____Rx Address:_____Rx phone:_____

Drug Name	Strength	Dosage Instructions	Quantity	Days Supply (34 retail)	Refills Indicate (#) duration of desired refills
Suboxone*					___Weeks: ___Months: ___ 1 year
Buprenorphine* EDD/Due Date:_____					___Weeks: ___Months: ___ 1 year

Requesting titration dose of: (+ or –) 2mg 4mg New Total Daily Dose _____
Please denote type of monthly monitoring: ❑UDT ❑Pill Counts ❑PMP

* Suboxone Film is the Preferred and **most cost-effective** drug in this category. *Buprenorphine will only be approved for use during pregnancy. Please refer to the bottom of this form or the preferred drug list at **www.mainecarepdl.org** for **complete Suboxone criteria**.

If Prior Authorization is being requested for a **non-preferred** drug in this category, use form 20420.

Medical Necessity

Section 1: General Questions

1. Is the patient pregnant? ❑ YES ❑ NO
2. Does the patient have a serious and persistent mental illness? Diagnosis_____ ❑ YES ❑ NO
3. Does the patient have one or more children, age 3 or younger, who primarily reside with the patient or for whom this patient is the sole responsible caregiver? ❑ YES ❑ NO
4. Other than those listed above are there any exceptional circumstances that would preclude this patient from attempting a taper? If yes, please Explain:

_____

Section 2: Titration History

5. Has the patient previously tried to titrate down the dose of buprenorphine? ❑ YES ❑ NO
6. Was the titration attempt successful? ❑ YES ❑ NO
7. Is there a plan to taper the dose within the next 12 months? ❑ YES ❑ NO
8. How long has patient been on current dose? _____
   If you answered **NO** to any of the above questions, please provide an explanation below:
   _____

Section 3: Level of Functioning

9. Is the patient currently engaged in recovery oriented supports or services? ❑ YES ❑ NO
10. Has the patient's level of functioning markedly improved since treatment initiation? ❑ YES ❑ NO
    Please describe below (i.e. Family, Legal, Social, Physical, Spiritual, Occupational, other):

Section 4: Relapse Risk

11. Is the patient at high risk of relapsing or has the patient already relapsed? ❑ YES ❑ NO
    Please explain what behaviors and circumstances indicate high risk of relapse, or if the patient has relapsed, please explain below _____

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**

Suboxone Criteria from **MaineCare Preferred Drug List www.mainecarepdl.org** **(ctrl F for search function).**

Members will continue to be required to follow the criteria listed below:

1-Induction period for new starts max of 60 days
2-Max dose of 32 mg for induction
3-Max dose of 16 mg for maintenance
4-There is not more than one narcotic fill in member's drug profile between today's fill of suboxone and a prior suboxone fill within the past 90 days.
5- Prescribers limited to those with X-DEA
6- Should be evidence provided of monthly monitoring including random pill counts urine drug tests and prescription monitoring program reports.
7-Suboxone tablets will be available upon demonstrated allergy to the preferred product. Allergy may be established by 1) formal allergy testing by a board-certified allergist or 2) demonstration of hives after skin exposure for 24 hours to the Suboxone Film. (The product may be applied to the skin using a band-aid and member can be assessed after 24 hours to ascertain the presence of hives by the prescriber).