MAGELLAN COMPLETE CARE

Prior Authorization

Suboxone®/Subutex®

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY)

__ __ / __ __ / __ __ __ __

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number

_ _ _ _ _ _ - _ _ _ _

Prescriber Fax Number

_ _ _ _ _ _ - _ _ _ _

Complete this section for initiation and continuation: **(Refer to page 2 for required documents and the prescriber's signature)**

Check one: ☐ Suboxone® ☐ Subutex® Dose: _______________ Directions: _______________________________________

Check one: ☐ Induction ☐ Stabilization ☐ Maintenance **Induction date** (required): ___________________________

Anticipated length of therapy:

1.	Is the patient pregnant or nursing?		Yes	No
	Expected date of delivery:			
2.	Is this request for the treatment of opioid dependence?		Yes	No
3.	Is this request for the treatment of pain?		Yes	No
4.	Is the patient taking other opioids, tramadol, or carisoprodol?		Yes	No
5.	Is the prescriber registered to prescribe Suboxone®/Subutex® under the Substance Abuse and Mental Health Services Administration (SAMHSA)?		Yes	No

Initiation of therapy or initial Medicaid review: (Supporting documentation is required for answers to all the questions)

1.	Does the patient have a confirmed DSM-IV-TR diagnosis of opioid dependency?		Yes	No
2.	Has an initial drug screen been performed to verify presence of opiates and other substances?		Yes	No
3.	Has the patient failed more than one prior attempt with opiate agonist treatment within the past 12 months?		Yes	No
	If yes, provide date(s) of relapse(s): ____			
4.	Does the patient have co-morbid conditions that would interfere with compliance?		Yes	No
	List:			
5.	What best describes the recovery environment for this patient?	Supportive	Unsupportive	Toxic
6.	Has the patient been referred to a support group or licensed mental health counselor for psychological counseling?		Yes	No
	If yes, specify: ____			
7.	Has the patient been referred for a psychiatric evaluation if indicated?		Yes	No
8.	Has the patient signed a contract (attach) and committed to both pharmacologic and non-pharmacologic modalities of treatment?		Yes	No
	Date of next office visit: ____			

Continued on page 2. Both pages of the Suboxone®/Subutex® prior authorization form must be submitted for review.

Fax or mail completed forms to:
Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

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Recipient's Full Name

Continuation of therapy: (Supporting documentation is required for answers to all the questions)

1. Has the patient failed more than one prior attempt with opiate agonist treatment within the past 12 months? Yes No
   Drug screen (attach) date: ____________________
2. Is the patient compliant with non-pharmacologic therapy? Yes No
   Provide details (support type [group or individual], frequency of attendance, dates) ____________________
3. How long has the patient been stable at the current dose? ____________________
4. Is the patient ready to taper the dose at this time? Yes No
   If no, provide rationale: ____________________
   If yes, provide taper schedule: ____________________
5. Is the revised individualized treatment plan reflecting follow-up at the most current office visit attached for review? Yes No
   Date of next office visit: ____________________

Prior Authorization Standards for Review:

Medicaid prior authorization review is intended for office-based treatment of opioid dependency for individuals who meet the following criteria:

- With an adequate amount of psychosocial support; family/peers
- With a readiness for change and a personal commitment to live a drug-free lifestyle
- With a willingness to comply with all elements of the treatment plan, including pharmacologic and non-pharmacologic aspects of the established protocol
- With consistent regular drug screens that are negative for opiates
- With a willingness to abstain from illicit drugs

Helpful links:

Medicaid resources the SAMHSA recommendations http://www.samhsa.gov/

National Library of Medicine for *Clinical Guidelines for Use of Buprenorphine in the Treatment of Opioid Addiction*
http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A72248

PRESCRIBER'S SIGNATURE: ____________________ **SAMHSA DEA#** ____________________

DATE: ____________________

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Magellan Complete Care		
MCC Physician Review:	I do not recommend Approval.	I recommend Approval for _________ months.
MCC Physician Signature: ____________________		**Date:** ____________________

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