

OHIO DEPARTMENT OF MEDICAID
Prior Authorization Form Suboxone/Zubsolv

Please refer to OAC § 4731-11-12 for reference

Request Date: ___/___/___

****Form must be completed and submitted by a physician with a Drug Addiction Treatment Act (DATA) 2000 waiver ID****

****Please ensure supporting documentation is provided****

Patient Medicaid ID#: _____ Name: _____ DOB: ___/___/___ <input type="checkbox"/> M <input type="checkbox"/> F	Prescriber's Name: _____ NPI#: _____ X-DEA#: _____ Prescriber Ph#: _____ Fax#: _____
If Known: Pharmacy Name: _____ Pharmacy Ph#: _____	

Regimen Requested: _____ Frequency: _____ Duration of Therapy: _____ Quantity: _____	<input type="checkbox"/> New <input type="checkbox"/> Renewal
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FOR NEW PRESCRIPTIONS (Suboxone/Zubsolv SL):

1. Has physician reviewed the OARRS report within 7 days prior to the prior authorization request? () YES () NO
2. Diagnosis (not approvable for pain): _____ ICD-10 Code: _____
3. Has patient been referred to counseling for addiction treatment? () YES () NO
4. For doses of Suboxone ≥ 16 mg per day or ≥ Zubsolv 11.4mg per day:
 - Was the dose established before 1/31/2015? () YES () NO
 - Please provide the prescriber's specialty: _____

RENEWAL CRITERIA (Suboxone/Zubsolv SL):

1. Please provide the current duration of treatment as of the date of this request: _____
2. Please indicate the frequency of physician meetings: _____
3. Has patient been actively participating in counseling AND has been compliant with all sessions? () YES () NO
Date of last counseling: _____ (1st year of treatment: attend minimum 12-step program meetings 3 times/week)
4. Has the dose been reduced in the past 6 months? () YES () NO
5. Has there been an evaluation for a dose reduction? () YES () NO
If NO, please provide explanation: _____
6. Has physician reviewed the OARRS report within 7 days prior to the PA request? () YES () NO
7. If patient has received controlled substances for ≥ 12 weeks since the last authorization, has the physician coordinated with all prescribers of controlled substances and determined treatment should continue? () YES () NO
If YES, has an addiction specialist recommended to continue substance abuse treatment? () YES () NO
8. Toxicology lab testing requirements met (monthly for 1st 6 months, then every 3 months)? () YES () NO
9. For doses of Suboxone ≥ 16 mg per day or ≥ Zubsolv 11.4mg per day:
 - Was the dose established before 1/31/2015? () YES () NO
 - Please provide the prescriber's specialty: _____

PLEASE CONTINUE ONTO THE NEXT PAGE. ALL PAGES MUST BE COMPLETED AND RETURNED.

Fax To: Ohio Department of Medicaid
Fax: **(800) 396 - 4111** PA Helpdesk: **(877) 518 - 1546**
Hours: Monday – Friday 8:00 am – 8:00 pm EST

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FOR ALL REQUEST INVOLVING A "NON-PREFERRED" MEDICATION
[Bunavail, Buprenorphine SL tablets, Buprenorphine/Naloxone SL tablets]

- A. For Buprenorphine:
- Is the patient pregnant? () YES () NO
 - Is the patient breastfeeding a methadone-dependent baby? () YES () NO
 - Does the patient have an allergy to naloxone? () YES () NO
- B. Is there a reason patient cannot use a preferred agent? () YES () NO
- Does the patient have a contraindication to preferred agent? () YES () NO
 - Does the patient have an allergy to the preferred agents? () YES () NO
 - Has the patient experienced an adverse effect(s) to a preferred agent? () YES () NO
 - Has the patient relapsed due to non-adherence or use of a preferred agent? () YES () NO

Additional Information: _____

****Form must be completed and submitted by a physician with a Drug Addiction Treatment Act (DATA) 2000 waiver ID****
****Please ensure supporting documentation is provided ****

Prescriber's Signature: _____ Date: ____/____/____
(Or agent of Prescriber)

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