OHIO DEPARTMENT OF MEDICAID

PRIOR AUTHORIZATION ORAL MEDICATION ASSISTED TREATMENT OF OPIOID USE DISORDER

Please refer to Ohio Administrative Code Chapter 4731-33, Chapter 4730-4, and rule 4723-9-13 for additional information.

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

Request Date		Review Type Requested ☐ Standard ☐ Urgent	
Individual's Medicaid ID Number		Prescriber's Name	
Name		NPI Number	X-DEA Number
Date of Birth	Sex ☐ Male ☐ Female	Prescriber's Phone Number	Fax Number
(If Known) Pharmacy Name		Pharmacy Phone Number	
Regimen Requested		Frequency	Duration of Therapy
		Quantity	☐ New ☐ Renewal
Sig:			

FOR NEW PRESCRIPTIONS

Safety edits are in place for dosages over 24mg of buprenorphine equivalents/day

Has physician reviewed OARRS within 7 days prior to the prior authorization request?		☐ Yes ☐ No
Diagnosis *(not approvable for pain)*	ICD-10 Code	
Has individual been referred to counseling for addiction treatment?		☐ Yes ☐ No
Has the individual been offered a prescription for a naloxone kit?		☐ Yes ☐ No
When is the individual's next appointment to assess induction therapy?	Date	

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

RENEWAL CRITERIA

Please provide the current duration of treatment as of the date of this request.		
Please indicate the frequency of physician meetings.		
Has individual been actively participating in counseling AND been compliant with all sessions? Date of last counseling		☐ Yes ☐ No
Has the dose been reduced in the past 6 months?		☐ Yes ☐ No
Has there been an evaluation for a dose reduction since the previous PA request? If NO, please provide explanation		☐ Yes ☐ No
Has physician reviewed Ohio Automated Rx Reporting System within 7 days prior to the PA request?		☐ Yes ☐ No
If individual is receiving opioids, benzodiazepines, sedative hypnotics, carisoprodol or tramadol, 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
Addiction Specialist consulted	Phone Number	Date
Lab testing requirements met *(at least twice per quarter for first year of treatment; once per quarter thereafter)?*		☐ Yes ☐ No

FOR ALL REQUEST INVOLVING A "BUPRENORPHINE MONO-PRODUCT"

Is the individual pregnant?	☐ Yes ☐ No
Is the individual breastfeeding?	☐ Yes ☐ No
Has the individual been explained the difference between an allergic reaction and symptoms of opioid withdrawal?	☐ Yes ☐ No
Does the individual have an allergy or other contraindication to naloxone? Please list reactions or reasons for contraindications.	☐ 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 *****

☐ I attest that I am a member of the prescriber's staff in accordance with Ohio Administrative Code rule 5160-9-03, as applicable. Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

______________________________ ____________________
Prescriber's Signature (or staff of prescriber) Date

____
IF a staff member is attesting, please print your name

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