

OHIO DEPARTMENT OF MEDICAID
Prior Authorization Oral Medication Assisted Treatment of Opioid Use Disorder

Please refer to OAC § 4731-33, 4730-4, and 4723-9-13 for reference

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

Request Date		Prescriber's Name	
Please ensure supporting documentation is provided Patient Medicaid ID Number			
Name		NPI Number	X-DEA Number
Date of Birth	Male Female	Prescribers Phone Number	Fax Number
(If Known) Pharmacy Name		Pharmacy Phone Number	
Regimen Requested		Frequency	Duration of Therapy
		Quantity	<input type="checkbox"/> New <input type="checkbox"/> Renewal

FOR NEW PRESCRIPTIONS

Has physician reviewed the OARRS report within 7 days prior to the prior authorization request?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis <i>(not approvable for pain)</i>	ICD-10 Code	
Has patient been referred to counseling for addiction treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient been offered a prescription for a naloxone kit?		<input type="checkbox"/> Yes <input type="checkbox"/> No
For doses of > 16 mg buprenorphine equivalents per day Please provide the rationale <i>(doses >24mg/day will not be authorized)</i>		
When is the patient'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 patient been actively participating in counseling AND has been compliant with all sessions? Date of last counseling		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the dose been reduced in the past 6 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has there been an evaluation for a dose reduction since the previous PA request? If NO, please provide explanation		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has physician reviewed the OARRS report within 7 days prior to the PA request?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If patient has received opioids, benzodiazepines, sedative hypnotics, carisoprodol or tramadol has the physician coordinated with all prescribers of controlled substances and determined treatment should continue?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, has an addiction specialist recommended to continue substance abuse treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Addiction Specialist consulted	Phone Number	Date
Lab testing requirements met (<i>at least twice per quarter for first year of treatment; once per quarter thereafter</i>)?		<input type="checkbox"/> Yes <input type="checkbox"/> No

FOR ALL REQUEST INVOLVING A "BUPRENORPHINE MONO-PRODUCT"

For Buprenorphine-only products		
Is the patient pregnant?	Yes	No
Is the patient breastfeeding?	Yes	No
Has the patient been explained the difference between an allergic reaction and symptoms of opioid withdrawal?	Yes	No
Does the patient have an allergy or other contraindication to naloxone?	Yes	No
Additional Information		

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

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I attest that I am a member of the prescriber's staff in accordance with OAC 5160-9-03.

Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

Prescriber's Signature (or staff of Prescriber & PRINTED name)

Date

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