

OHIO DEPARTMENT OF MEDICAID
Prior Authorization SUBLOCADE (*buprenorphine extended-release injection*)
Please refer to OAC § 4731-33 and 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****

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

Request Date	Patient Medicaid ID Number	Prescriber's Name	
Name		NPI Number	X-DEA Number
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Prescriber Phone Number	Prescribers 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
Is the patient ≥18 years and currently established on a dose of at least 8 mg of oral buprenorphine for at least 7 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If patient has received opioids, benzodiazepines, sedative/hypnotics, carisoprodol, or tramadol, has the physician consulted with all prescribers of controlled substances and determined that treatment should continue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, has the Addiction Specialist recommended to continue substance abuse treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Addiction Specialist consulted Phone Number _____ Date _____	
Diagnosis _____ ICD-10 Code _____	
Is the patient actively participating in counseling and compliant with all sessions? Date of last counseling _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a medical justification that supports the inability to continue to use an oral formulation? Rationale _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a urine drug screen result been obtained within the last 7 days with no illicit substances or non-prescribed therapies detected?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Documentation provided shows adherence to counseling, OARRS, and urine drug screening requirements in treatment plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does maintenance dose exceed 100 mg?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please provide rationale	



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

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

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