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PA#:
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www.ppmco.org
6704 Curtis Court
Glen Burnie, MD 21060

Suboxone / Subutex Prior Authorization Form

Questions? Contact the Pharmacy Dept at:
(410) 424-4490, option 4 or
(888) 819-1043, option 4

FAX Completed form to: (410) 424-4607

Download a copy of this form on our website at: **www.ppmco.org**

Member Info (Please Print Legibly)		
NAME:		MEDICAID #:
DOB:	SEX:	PPMCO #:
Provider Info		
NAME:		Office Telephone:
Office Contact Name:		Office FAX:
Buprenorphine DEA# ('X'):		

Medication Requested			
Drug Name	**Strength**	**Dosage/Frequency (SIG)**	**Duration of Therapy**

Clinical Information	
ICD-9 Diagnosis (patient must meet DSM-IV-TR criteria for **Opiate Dependence**):	
Is patient being converted from methadone? ☐**Yes** ☐**No** If yes, current methadone dose:	
*Is this Initial Treatment (first 90 days)? ☐**Yes** ☐**NO**	**Is this Maintenance Treatment? ☐**Yes** ☐**No**

*Patients may be approved initially for 2 months of therapy. If after 2 months, the patient continues to test positive with no significant reduction in drug use, the patient should be referred for more comprehensive substance abuse treatment (if he/she is not currently engaged in such). For additional information on locating a substance abuse provider/treatment facility, contact **Johns Hopkins Behavioral Health Services at 1-800-261-2429.**

**Patients with no pharmacy claims for opiate medications in the past two months may be approved for 6 months of therapy. Patients with positive urine screens will receive approval at additional two-month intervals and be referred to Behavioral Health Services. Patients with 2 consecutive monthly negative urine screens, who are receiving counseling, may be approved for up to 6 months. Established patients (≥ 6 months of negative screens) may be approved for 6 months of continuing therapy.

URINE SCREEN – Please attach of report(s)									
DRUG CLASS	**Date:**			**Date:**			**Date:**		
	Positive	Negative	Not Tested	Positive	Negative	Not Tested	Positive	Negative	Not Tested
Benzodiazepine	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cannabinoid	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	☐	☐	☐	☐	☐
OPIATES	☐	☐	☐	☐	☐	☐	☐	☐	☐
Methadone	☐	☐	☐	☐	☐	☐	☐	☐	☐

I certify that the clinical information provided on this form is complete and accurate.

Provider Signature: ____ **Date:** _________________

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☐ Approved:	Duration of Approval: _____ month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	Name:
Date Faxed to MD:	Date Decision Rendered:

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