



www.ppmco.org
 6704 Curtis Court
 Glen Burnie, MD 2106

**Suboxone / Subutex
 Prior Authorization Form**

For Internal Use Only
PA#:
Date Entered:

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

FAX Completed form to:
(410) 424-4607 *or* (410) 424-4751

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, current methadone dose:	
*Is this Initial Treatment (first 90 days)? <input type="checkbox"/> Yes <input type="checkbox"/> NO	**Is this Maintenance Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabinoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OPIATES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Provider Signature: _____ **Date:** _____

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: _____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	Name:
Date Faxed to MD:	Date Decision Rendered: