NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION
BUPRENORPHINE/NALOXONE AND BUPRENORPHINE

PRESCRIBING PHYSICIAN: MEDICAID RECIPIENT:

Name: _____ Name: _____
(First, Last) (First, Last)

Phone #: (_____)-_____-_____ Medicaid # _____

Fax #: (_____)-_____-_____ Date of Birth: __/__/____

NPI #: _____ **(Note: patient must be 16 years or older).**

DEA #: _____ **Male** ☐ **Female** ☐

PARTICIPATING PHARMACY:

Name: _____ Request Date: _____

Phone #: (_____)-_____-_____ Fax #: (_____)-_____-_____

Drug	**Strength:**	**Qty Per Day:**	**Maximum Duration of Prior Authorization 12 Months**
Buprenorphine/ Naloxone film			
Buprenorphine/Naloxone tablet			
Buprenorphine tablet			

Diagnosis confirmed as treatment of Opioid Use Disorder and not pain management: ☐Yes ☐No
****ABOVE PRODUCTS ARE NOT COVERED FOR PAIN MANAGEMENT****

INITIAL REQUEST RENEWAL REQUEST

1. Prescriber has been issued an "X" DEA license number to prescribe? ☐Yes ☐No
2. Does the patient have other opioid (including tramadol) or benzodiazepine medications prescribed at time of buprenorphine initiation? (must be discontinued for authorization) ☐Yes ☐No
3. Has the patient signed a contract (*or Informed Consent*)? (attach either clinic standard form or Nebraska form) ☐Yes ☐No
4. Is the patient pregnant or nursing? ☐Yes ☐No
   Expected delivery date:_____
5. For renewal: Has patient been compliant with contract (or Informed Consent) and had appropriate random urine drug screening results? ☐Yes ☐No

Submit request to: Pharmacy Services Fax: 833-404-2254, Tel: 844-330-7852
Submit prior authorization (PA) requests electronically through our preferred solution **CoverMyMeds** at CoverMyMeds.com/main/prior-authorization-forms/.