05/05/14

Prior Authorization Form

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Suboxone, Buprenorphine (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250.**
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Suboxone, Buprenorphine (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Buprenorphine sublingual tablets
Buprenorphine-Naloxone Film
Buprenorphine-Naloxone SL Tablets
Suboxone Film (buprenorphine-naloxone)
Quantity ___________
Frequency _________________
Strength ____________
Route of Administration ___________
Expected Length of therapy ________________

Patient Information

Patient Name: ____
Patient ID: ____
Patient Group No.: ____
Patient DOB: ____
Patient Phone: ____

Prescribing Physician

Physician Name: ______________________________
Physician Phone: ______________________________
Physician Fax: ______________________________
Physician Address: ______________________________
City, State, Zip: ______________________________

Diagnosis:_________________________________ **ICD Code:**_________________________________

Please circle the appropriate answer for each question.

1. Is this request for the management of opioid dependence? Y N

   [If the answer to this question is no, then forward to a pharmacist to review.]

2. Is the patient 16 years of age or older AND enrolled in a substance abuse treatment program and/or receiving psychosocial counseling? Y N

   If the answer to this question is no, then forward to a pharmacist to review.]

3. Does the prescriber possess a DATA 2000 waiver (is SAMHSA certified)? If yes, please provide prescribing physician's XDEA number: Y N

   [If the answer to this question is no, then forward to a pharmacist to review.]

4. Is the request for (Subutex) buprenorphine? Y N

   [If the answer to this question is no, then skip to question 9.]

5. Is (Subutex) buprenorphine being used as INDUCTION treatment of opioid dependence? Y N

   [If the answer to this question is yes, then skip to question 12.]

6. Is the patient pregnant? Y N

   [If the answer to this question is no, then skip to question 8.]

7. Is the patient seeing an Obstetrician/Gynecologist? If yes, please provide documented consultation with OB/GYN. Y N

   [If the answer to this question is no, then forward to a medical director for review.]

   [No further questions required.]

8. Did the patient have a trial and failure, an allergy, or has a contraindication to (Suboxone) buprenorphine/naloxone? If yes, please document: Y N

   [If the answer to this question is no, then forward to a pharmacist to review.]

9. Has Aetna Better Health Illinois authorized the requested medication in the past for this patient (e.g. previous authorization is on file under Aetna Better Health Illinois)? Y N

   [If the answer to this question is no, then skip to question 12.]

10. Has a urine drug screen been performed within the last 30 days AND are positive results other than buprenorphine (e.g., benzodiazepines, amphetamines, illicit drugs, other opioids) addressed in the treatment plan? If yes, please document positive results (if any other than buprenorphine) and detailed treatment/tapering plan: Y N

    [If the answer to this question is no, then forward to a pharmacist to review.]

11. Is the patient currently taking any opiates or tramadol? Y N

    [If the answer to this question is yes, then forward to a pharmacist to review.]

12. Is the dosing requested greater than 24mg daily? Y N

    If the answer to this question is no, then no further questions required.]

    [If the answer to this question is no, then forward to a pharmacist to review]

13. Has duration and timeline for taper to a lower dose been anticipated? If yes, please document timeline for taper/treatment plan: Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**