Nevada Medicaid

Submit fax request to: 855-455-3303
Please note: All information below is required to process this request.

Bunavail®, buprenorphine, buprenorphine-naloxone, Suboxone®, Zubsolv®
Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Opioid dependence

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the requested medication being prescribed by a physician with a Drug Addiction Treatment Act (DATA) of 2000 waiver who has a unique "X" DEA number? ❑ **Yes** ❑ **No**

If **Yes** to the above, please document the DEA "X" number: _____

Is there documentation that the member has honored all of their office visits? ❑ **Yes** ❑ **No**

Is the member currently utilizing an opioid or tramadol? ❑ **Yes** ❑ **No**

If **Yes** to the above, is there documentation stating the member will discontinue opioid use prior to initiation of the requested medication? ❑ **Yes** ❑ **No**

Will the member utilize opioids, including tramadol, concurrently with the requested medication? ❑ **Yes** ❑ **No**

For buprenorphine sublingual tablet requests, also answer the following:

Is there documentation that the member is pregnant or is breastfeeding an infant who is dependent on methadone or morphine? ❑ **Yes** ❑ **No**

Does the member have moderate to severe hepatic impairment (Child-Pugh class B or C)? ❑ **Yes** ❑ **No**

Has the member had an allergy to buprenorphine/naloxone? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

Please provide the member's treatment plan (or provide chart documentation [e.g., medical records] showing the member's treatment plan): _____

_____

_____

_____

Is there documentation in the member's medical record that the requested dose is the lowest effective dose for the member? ❑ **Yes** ❑ **No**

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Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-455-3311.
This form may be used for non-urgent requests and faxed to 1-855-455-3303.