AmeriHealth Caritas New Hampshire

Suboxone®/Buprenorphine

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
Specialty:		NPI number:	
Phone #:	Fax #:		

Clinical history
1. Is this request for treatment of opiate use disorder? ☐ Yes ☐ No If no, what is the diagnosis for usage:
2. Does prescriber have a substance abuse and mental health services administration waiver? ☐ Yes ☐ No
3. Is the patient receiving addiction counseling? ☐ Yes ☐ No
4. Has a substance use disorder assessment been performed? ☐ Yes ☐ No
5. Is the patient's age 16 years of age or older? ☐ Yes ☐ No
6. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? ☐ Yes ☐ No
7. If approved; will the patient require concurrent opioid medication or Methadone therapy? ☐ Yes ☐ No
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.