Arkansas Medicaid Medication Assisted Treatment (MAT) Pharmacotherapy
Injectable Buprenorphine-Containing Agents
Statement of Medical Necessity

After completion of this form, please fax to the Arkansas Medicaid Pharmacy Unit for prior authorization review.
Fax: 1-800-424-5851 for SUBLOCADE™ AND PROBUPHINE® requests. **For questions call: 1-501-683-4120**.

AR MEDICAID ENROLLED PRESCRIBER ID NUMBER: **MEDICAL BILLING PRESCRIBER MEDICAID ID NUMBER:**	**AR MEDICAID BENEFICIARY ID NUMBER:**
PRESCRIBER NAME:	**BENEFICIARY NAME:**
ADDRESS:	**ADDRESS:**
CITY: STATE: ZIP:	**CITY: STATE: ZIP:**
PHONE: ( )	**BENEFICIARY'S DATE OF BIRTH: / /**
FAX: ( )	
NAME OF PERSON (NURSE OR CLINIC REPRESENTATIVE) TO CONTACT IF THERE IS ADDITOIINAL INFORMATION NEEDED FOR PA PROCESSING:	**MEDICAL BILLING ONLY**
MARK THE DRUG / STRENGTH FOR A PA REQUEST. **SUBLOCADE™ SQ 100MG (buprenorphine)** ☐ **SUBLOCADE™ SQ 300MG (buprenorphine)** ☐ **PROBUPHINE® IMPLANT (buprenorphine)** ☐	**NOTE: Preferred oral buprenorphine products do not require a prior authorization. For updated preferred list, please refer to: https://arkansas.magellanrx.com/client/docs/rxinfo/PACriteria.pdf**

Per SAMHSA--Medication-Assisted Treatment (MAT) is the use of *FDA- approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the* ***treatment of substance use disorders.***

Initial PA request (Once the following information is provided, the PA can be approved 6 months):

a. If this is the prescriber's first time to request a prior authorization from AR Medicaid for a buprenorphine-containing agent for any beneficiary, the prescriber must submit a copy of his/her **X-DEA license number** for prescribing buprenorphine-containing agents and a **copy of the approved SAMHSA Waiver** (this only needs to be submitted one time with the prescriber's first patient and the Medicaid Pharmacy Program will retain the information); **AND**

b. Do you attest that this patient is being treated for opioid use disorder? **YES** ☐ **NO** ☐

c. Have you referred this patient to behavioral health counseling with a Medicaid enrolled provider? **YES** ☐ **NO** ☐

If you have not been able to identify a behavioral health provider, please refer to:
https://humanservices.arkansas.gov/images/uploads/dbhs/Outpatient_Behavioral_Health_Provider_Directory_7-26-19.pdf

d. Current urine drug screen for **SUBLOCADE™ AND PROBUPHINE®** requests;

Renewal request (Once the following information is provided, the PA can be extended 6 months):

a. Current urine drug screen; **AND**

b. Do you attest that this patient is receiving regular behavioral health counseling from a Medicaid enrolled provider in conjunction with taking this medication? **YES** ☐ **NO** ☐

c. Provide date of beneficiary's last dose_____

Prescriber Signature: _____ **Date:** _____
Prescriber's original signature required; copied, stamped, or e-signature are not allowed. By signature the prescriber confirms the criteria information above is accurate and verifiable in patient records.

******Please note that all information attested to herein is subject to Medicaid review and audit.*******