

Alabama Medicaid Pharmacy
Opioid Dependence Treatment PA Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36831-3210

PATIENT INFORMATION

Patient Name _____ Patient Medicaid # _____

Patient DOB _____ Patient Phone # with Area Code _____

PRESCRIBER INFORMATION

Prescriber Name _____ NPI # _____ License _____

Phone # with Area Code _____ Fax # with Area Code _____

Address (Optional) _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record

Prescribing Provider Signature

Date

DRUG/CLINICAL INFORMATION

Drug Requested: Buprenorphine Buprenorphine/Naloxone Bunavail
 Suboxone Sublocade Zubsolv

Strength _____ NDC Code _____

Qty. Per Month _____ Days' Supply _____ Requested Refills _____

Daily Dose/Directions to Patient for Use _____

Diagnosis or ICD-10 Code _____

Initial Request Renewal Request

Medical Justification _____

Physician Attestation (must be manually signed by the prescribing physician): I certify that I have reviewed the patient's records in the state's prescription drug monitoring program (PDMP) within the past 2 weeks and that to the best of my knowledge, the patient is not diverting the requested medication nor is that patient simultaneously receiving prescriptions for opioid medications.

Prescribing Provider Signature

Date

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing Pharmacy _____ NPI # _____

Phone # with Area Code _____ Fax # with Area Code _____