Alabama Medicaid Pharmacy
Opioid Dependence Treatment PA Request Form

FAX: (800) 748-0116 | **Fax or Mail to** | **P.O. Box 3210**
Phone: (800) 748-0130 | **HEALTH INFORMATION DESIGNS** | **Auburn, AL 36832-3210**

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: □ Bunavail □ Suboxone □ Zubsolv □ Buprenorphine □ Buprenorphine/Naloxone

Strength_____ NDC Code_____

Qty. per month_____ Days' supply_____ Requested Refills _____

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_____

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