

**Alabama Medicaid Pharmacy
Short Acting Opiate Naïve Days' Supply Limit Override**

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 attest that all information included within this request is accurate. 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 _____ Strength _____ Drug Code _____
Quantity Requested _____ Days' Supply for Quantity Requested _____
Diagnosis/ICD-10 Code _____
Medical Justification _____

The questions below must be completed in order for requests to be considered for approval:

- Has the patient tried and failed at least one 5 day treatment trial with a non-opioid therapy in the past 14 days (ex. acetaminophen, nsaid, etc.)? Yes No If yes, indicate failed therapy, length of treatment trial, and date treatment ended: _____
- Has the prescriber reviewed the patient's PDMP prior to prescribing the requested medication? Yes No
- For female patients, has the patient been counseled on the risk of being/ becoming pregnant while on the requested medication, including the risk of neonatal abstinence syndrome (NAS)? Yes No
- Has the prescriber counseled the patient on the risk of concurrent use of the requested medication with benzodiazepines, sedative/hypnotics, or barbiturates? Yes No

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing Pharmacy _____ NPI # _____
Phone # with Area Code _____ Fax # with Area Code _____
