Alabama Medicaid Pharmacy
Opioid Dependence Treatment PA Request Form

FAX: (800) 748-0116 | **Fax or Mail to** | **P.O. Box 3570**
Phone: (800) 748-0130 | **KEPRO** | **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_____