



**Buprenorphine & Buprenorphine/Naloxone Products  
Used to Treat Opioid Addiction  
Prior Authorization Request Form**

**Beneficiary Information**

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Name: \_\_\_\_\_  
Medicaid ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Billing Provider Information (Pharmacy, Physician, or Facility)**

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Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Requested Drug: \_\_\_\_\_ NDC: \_\_\_\_\_  
Dosage/day: \_\_\_\_\_

**Prescriber Information**

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Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Requested Information (Required for Initial Requests)**

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1. Does patient have a diagnosis of opioid dependence?  Yes  No
2. Is patient actively involved in addiction treatment?  Yes  No
3. Does prescriber have a current 'X'DEA number?  Yes  No
4. Does prescriber practice in Kansas or a border city?  Yes  No
5. Is prescriber enrolled with KMAP?  Yes  No
6. Is patient pregnant?  Yes  No
7. Does patient have a documented medical allergy to naloxone?  Yes  No

**Requested Information (Required for Renewal Requests)**

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1. Has patient received any other narcotic agents since last prior authorization approval?  Yes  No
2. Has prescriber reviewed the patient's K-TRACS profile and confirmed patient is not receiving any narcotic agents in addition to the buprenorphine agent?  Yes  No
3. If the patient has received narcotics since the last prior authorization approval, please provide reason for use and the patient treatment plan. (May attach additional information to request.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.  
This form will be returned unprocessed if it is not completed in its entirety.**