TeamstersCare Substance Use Disorder Ambulatory Medication Assisted Treatment Prior Authorization Form

- Complete and fax to 781-321-6501. Phone 1-800-851-8326
- Standard response time is 24-48 hours from date all data received

PATIENT INFORMATION

Patient Name:

Date of Birth: TeamstersCare ID#:

Patient Address:

Patient Phone: E-mail:

PROVIDER INFORMATION

Provider Name: Degree: Specialty:

Office Phone: Office Fax: Office Contact Name:

NPI No.: DEA No.:

TYPE OF REQUEST

☐ Initial request and induction only ☐ Continuation request only

MEDICATION INFORMATON - MEDICATION REQUESTED

☐ Vivitrol* ☐ Buprenorphine Tablet** ☐ Buprenorphine/Naloxone Film**

☐ Naltrexone ☐ Acamprosate – Campral ☐ Buprenorphine/Naloxone Tablet**

*Limited to 6 injections per lifetime.

**For doses greater than 16 mg per date, provide clinical rationale including documentation of why this higher dose is medically necessary. Doses greater than 24 mg a day will not be approved.

Has the prescriber reviewed the Massachusetts prescription monitoring program before the initiation of therapy?
☐Yes ☐ No

Fill date of last opioid prescription: _____

Fill date of last benzodiazepine prescription: _____

If buprenorphine, has the provider identified any opioid, benzodiazepine, sedative, or stimulant medications fourteen (14) days prior to requested initiation of buprenorphine therapy? ☐Yes ☐ No

PRESCRIBING PROVIDER CONFIRMATION, SIGNATURE AND DATE

I certify to the pains and penalties of perjury that I am the prescribing provider identified in the prescribed information section of this document. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical assistance information per 130 CMR 460.204 on this form is true, accurate and complete to the best of my knowledge. I understand that I may be subject to civil penalties and criminal prosecution for any falsification, omission or concealment of any material fact contained herein.

☐ **I have confirmed that this patient is not in a safety sensitive position of employment and/or operating machinery.**

Provider Signature: _____ **Date:**_____

Printed Name of Provider: _____

(Over)

Patient Name: _____

Medication Requested: _____

FOR TEAMSTERSCARE USE ONLY	
Eligibility Verified ☐	**Notes:**
Program: Active ☐ ERMP ☐ RRX☐	
Prior PA? Yes☐ No ☐ If Yes, Date:	
Form Complete/Legible ☐	
Authorized ☐ Pending ☐ Denied ☐	**Reviewer :** **Date:**