Mountain Pacific
INNOVATING BETTER HEALTH
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Montana Healthcare Programs
Buprenorphine Induction Therapy for Opioid Substance Use Disorder

Patient Name:	Patient Medicaid ID#:	Patient DOB:
Provider Name:	Provider DEA# (**X-DEA required**):	
Provider Phone #:	Provider Fax #:	
Starting Date of Induction:	Dose Requested (2mg or 8mg tablets):	
Directions for Induction:	Estimated Quantity Needed:	
Anticipated Length of Induction (*note: if longer than 7 days, please provide rationale*):		
Request for Emergency Kit Replacement Only (*see additional requirements in Question 3*) Requested Dose and Quantity:		

1. ☐ Provider is a Montana Healthcare Programs-enrolled provider and, as such, adheres to the requirements in the Addictive and Mental Disorders Division (AMDD) MAT policy. The complete policy can be found here: Policy Number 550 (mt.gov).

2. **Provider attests patient Treatment Plan** includes **all** the following (please check) and **will be documented** in patient chart:
   - ☐ Patient is 16 years of age or older.
   - ☐ Patient assessment/screening supports a diagnosis of **moderate to severe opioid substance use disorder (SUD)** (Diagnostic and Statistical Manual, 5th Edition [DSM-V] criteria).
   - ☐ Behavioral health assessment and engagement in counseling will be recommended. If recommendation accepted, referral assistance will be provided if resources are available. If patient is not ready for change, periodic re-assessment of readiness will occur. Lack of counseling is not a reason to withhold treatment.
   - ☐ Proposed monitoring plan includes random pill counts and random urine drug screens (to include drugs of abuse **and** buprenorphine).
   - ☐ Treatment contract, **including patient's acknowledgement of his/her understanding of section "A" below**, has been signed by patient. ***The department may request a copy of the signed treatment contract at any time.***

3. **For emergency kit replacement, this additional documentation is required:**
   - ☐ For approval consideration, emergency kit logs specific to the member for whom the medication is being requested **are attached for review** and meet the requirements spelled out in ARM 24.174.1114.

LIMITATIONS:

A. **Concurrent opioids, tramadol or carisoprodol will NOT be covered with buprenorphine-containing products.** If a patient *subsequently discontinues the buprenorphine-containing product, all opioids, tramadol formulations and carisoprodol will remain on not-covered status. These medications will require prior authorization for any future prescriptions*. Approval may be granted short-term for an acute injury, hospitalization

or other appropriate diagnosis *only* after the case is reviewed with the treating provider and the provider prescribing the buprenorphine-containing product.

Signature of Provider: _____ Date: _____

Please complete form and fax to
Montana Healthcare Program's Prior Authorization Unit at 1-800-294-1350.

9/2023