This form is for behavioral health providers (not PCPs) to request approval of non-formulary medication assisted treatment (MAT) for members diagnosed with Opioid Use Disorders or Alcohol Use Disorders.

**NOTE: PA not required for Methadone, Suboxone or Subutex Tablets, or Naltrexone Tablets**

***Confidentiality Notice:*** *The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via Fax) immediately and arrange for the return or destruction of these documents.*

**Please complete all fields (for one medication) legibly and provide supporting medical records.**

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| [ ]  **URGENT REQUEST (Initial response within 24 hours)**By selecting this option and signing this form below, I certify that applying the standard review time of up to 72 hours will seriously jeopardize the *life or health of the member* or the member’s ability to regain maximum function. |

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| **Member Information** |
| First Name:       | MI:       | Last Name:       |
| Date of Birth:       | Gender:       |
| Member ID:       | Member Phone:       |
| Member’s Health Share Behavioral Health Plan *(please select one)*: |
| [ ]   | Multnomah County Behavioral Health Plan |
| [ ]   | Clackamas County Behavioral Health Plan |
| [ ]   | Washington County Behavioral Health Plan |

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| **Prescriber Information**  |
| Prescriber Name:       | Specialty:       |
| NPI or DEA:       | Office Phone:       |
| Contact Person:       | Office Fax:       |

*Continued on next page*

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| **Diagnosis and Medical Information Related to Request**  |
| **Note: PA Is not required for Methadone, Suboxone, or Subutex Tablets, or Naltrexone Tablets** |
| Diagnoses:       |
| Medication:  | [ ]   | Naltrexone ER Injection (Vivitrol) |
|  | [ ]   | Buprenorphine / Naloxone Sublingual Film (Suboxone SL Film) |
|  | [ ]   | Other:       |
| Dosage/Route of Administration:       |
| Frequency:       | Quantity:       |
| [ ]  New Medication / Medication Start Date:       |
| Expected Length of Therapy:       |
| Drug Allergies:       |
| Other Health Conditions:       |

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| **Rationale for Request of Prior Authorization**  |
| List all alternate drugs previously tried, but with adverse outcomes (e.g. toxicity, allergy or therapeutic failure) below: |
| Drug Tried | Adverse Outcomes | Dose & Duration |
| 1)       | 1)       | 1)       |
| 2)       | 2)       | 2)       |
| 3)       | 3)       | 3)       |

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| Clinical rationale for treatment and statement of medical necessity (attach supporting medical records):  |
|       |

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| Pertinent laboratory tests and results (attach copies of results):  |
|       |

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| **Prescriber’s Signature:** |  | **Date:** |       |

Upon completion of this form, please submit, with all appropriate clinical documentation via

**SECURE EMAIL** to: **nimisha.gokaldas@multco.us**

**For Questions or Assistance, please contact:**

Multnomah County Member Services: 503-988-5887

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