State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
Suboxone/Buprenorphine Continuation

Phone: 1-888-445-0487 | ONE Drug Per Form ONLY – Use Black or Blue Ink | Fax: 1-888-879-8830

Member ID #: |_|_|_|_|_|_|_|_|_| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address: _____

Provider DEA: |_|_|_|_|_|_|_|_|_| Provider NPI: |_|_|_|_|_|_|_|_|_|_|

Provider Name: _____ Phone: _____

Provider Address: _____ Fax: _____

Pharmacy Name: _____ Rx Address: _____ Rx phone: _____

Drug Name	Strength	Dosage Instructions	Quantity	Days Supply (34 max)	Refills
Suboxone	_____	_____	_____	_____	1 2 3 4 5
Buprenorphine	_____	_____	_____	_____	1 2 3 4 5

Requesting current titration dose of _____ (+ or – 4mg)

Medical Necessity Documentation

Is the patient currently engaged in recovery oriented supports/services?

☐ Yes
☐ No

Has the patient's level of functioning markedly improved since starting treatment with Suboxone?

☐ Yes
☐ No

Describe evidence of improvement in the following areas that apply to the patient:

☐ Family

_____

☐ Legal

_____

☐ Social

_____

☐ Physical

_____

☐ Occupational

_____

☐ Spiritual

_____

☐ Other

_____