MICHIGAN
Department Of Community Health Pharmacy Program
Verification of Treatment Program & Clinical Information
SUBOXONE® (*Buprenorphine / Naloxone*)

All information on this form must be addressed. Incomplete forms will be returned only once for missing information. Mark as 'N/A' if no information is available or does not apply. Issues that remain blank after being returned once will receive a denial and will not qualify for MDCH physician review until completed or clearly marked 'N/A'.

Prescribing Physician:

Name: ______________________
First Last

Phone #: [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]

Fax #: [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]

DEA X #: [ ][ ][ ][ ][ ][ ][ ][ ][ ]

NPI: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]
NPI accepted as of April 17, 2007

Beneficiary: Male Female

Name: ______________________
First Last

Medicaid #: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Date of Birth: [ ][ ]-[ ][ ]-[ ][ ][ ][ ]

DEA X # Exp: [ ][ ]-[ ][ ]-[ ][ ][ ][ ]

Specialty: ______________________

Person completing form: ______________________ **Rqstd start date:** __________
Name Title Date

Pharmacy: ______________________
(If known)

Phone #: [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]
(If known)

Medication:	Strength:	Qty / Day:	Maximum Duration of Treatment	
SUBOXONE®			12 Months	
Diagnosis confirmed as treatment of opioid dependence & not pain management:			YES	NO
*** SUBOXONE® IS NOT COVERED FOR PAIN MANAGEMENT ***				

Explain all "NO" answers at the end of this form.

		YES	NO
1.	The prescriber has been issued an "X" DEA license number to prescribe Suboxone®.	Y	N
2.	Prescriber has the capacity to refer the patient to an evidence-based substance dependency counseling and monitoring program.	Y	N
3.	Patient has been advised of other treatment options.	Y	N
4.	Patient has signed an informed consent form or treatment contract.	Y	N
5.	Patient is established with the prescribing physician & has been compliant w/appts.	Y	N
6.	Patient is undergoing active, formal, substance abuse counseling.	Y	N
	• If the prescriber named above is a psychiatrist or certified addiction specialist, he/she must attest to the fact that he/she is rendering the counseling.	Y	N

- If the prescriber named above is not a psychiatrist or certified addiction specialist, then we must have the name of the psychiatrist or certified addiction specialist who will render the services, that person's license number, and the program's license number.
  Mark as 'N/A' if no information is available and cannot be provided.
  Name of the psychiatrist or certified addiction specialist:

  ____

  Program/Agency name:

  ____

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Submit requests to: First Health Services, MAP Department, 4300 Cox Road, Glen Allen, VA 23060
Fax: 888-603-7696 Phone: 877-864-9014
This form is available at www.michigan.fhsc.com -> Providers -> Forms

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Prescribing Physician:

Name: ______________________________
First Last

Phone #: [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]

Beneficiary: Male Female

Name: ______________________________
First Last

Medicaid #: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Is the patient CURRENTLY pregnant? If so, please document the expected delivery date in the space below and forward any supporting documentation available from the recipient's OB/GYN. If there is no information available from the OB/GYN, please note as such below.

ADDITIONAL COMMENTS

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If approvable, the initial approval will be granted for six months of therapy. An extension of six months may be requested (total of twelve months of therapy).

- **Initial requests and requests for the six-month extension may be submitted on this form or by phone. Requests for therapy exceeding twelve months MUST be submitted on this form and will be forwarded to MDCH. Please include patient-specific reasoning for the requested extension.**
- **Requests for Suboxone® at a dosage greater than 24mg of buprenorphine per day (any combination of the two strengths), requires a written explanation of the dosage requirement from a psychiatrist or certified addiction specialist citing the clinical basis for the higher dose (use the space above to document).**
- **Medicaid also has quantity limits of three tablets per day for the 8mg-2mg strength and four tablets per day for the 2mg-0.5mg strength. Please use the higher strength tablet whenever clinically suitable. Requests for quantity overrides will be forwarded to MDCH.**

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