FAX completed form to **Optum Rx 1-866-964-3472**

Wyoming Medicaid – Pharmacy Services Program
PRIOR AUTHORIZATION REQUEST FORM

PHONE:
(For questions or inquiries ONLY)
1-877-207-1126

Sublocade® Prior Authorization Request Form

Provider must fill in all information below. It must be legible, correct and complete or the form will be returned.

Client ID #: |___|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Client's Full Name: _____ DOB: _____

Prescriber NPI: |___|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: |____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Pharmacy Name: _____ Phone: _____

Drug Name (List one drug per form)	**Strength**	**Dosage Instructions**	**Days Supply**	**Quantity**	**Refills**

Client's medical diagnosis: _____

1. **For new and initiating treatment, prior authorizations will be approved per indicated dosing schedule with a maximum of 600mg for the first month. Maintenance dosing will be limited to 100mg monthly. Please check which therapy is being requested:**

   ☐ **Initiation dose: 300mg starting dose, with second 300mg injection between 7-30 days after initial injection**

   - **Injection #1 Date _____ Injection #2 Date _____**

   ☐ **Maintenance dose: 100mg monthly**

   ☐ **Maintenance dose: 300mg monthly**
   ***May be considered in patients who tolerate 100mg monthly, but do not demonstrate a satisfactory clinical response.**
   ****Maintenance doses should be administered with at least 26 days between injections.**

2. **Has the client received at least one transmucosal buprenorphine dose?** ☐ **Yes** ☐ **No**
   **Clients will not be allowed to use oral buprenorphine products concomitantly with Sublocade. Clients will also not be allowed to receive concurrent benzodiazepine therapy with Sublocade. See the Medicaid Pharmacy Provider Manual at https://www.wymedicaid.org/provider/provider-manual.html for more information.

3. **Has the Wyoming Prescription Drug Monitoring Program (AWARxE) been reviewed for this client?** ☐ **Yes** ☐ **No**
   If yes, most recent date accessed: _____

***** Please contact the Optum Rx Pharmacy Service desk for instances where the product has been ordered for a member and the prescription was unable to be completed.**

Prescriber Signature: _____ **Date(s) of Submission:** _____

**** By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.***