MAT Prior Authorization Request Form

This form is for behavioral health providers (not PCPs) to request approval of 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, Vivitrol or Naltrexone Tablets

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

Member Information

First name: _____ MI: _____ Last name: _____

Date of birth: _____ Gender: _____

Member ID: _____ Member phone: _____

Prescriber Information

Prescriber name: _____ Specialty: _____

NPI or DEA: _____ Office phone: _____

Contact person: _____ Office fax: _____

Diagnosis and Medical Information Related to Request

Note: PA Is not required for Methadone, Suboxone or Subutex Tablets, Vivitrol or Naltrexone Tablets

Diagnoses: _____

Medication: ☐ Sublocade (Buprenorphine ER Injection)

☐ Other: _____

Dosage/route of administration: _____

Frequency: _____ Quantity: _____

New medication/medication start date: _____

Expected length of therapy: _____

Drug allergies: _____

Other health conditions: _____

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 and duration
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

Clinical Rationale For Treatment and Statement of Medical Necessity

(attach supporting medical records):

Pertinent Laboratory Tests and Results *(attach copies of results):*

Prescriber's signature: _____ Date: _____

Providers must fax all authorization request forms and attachments to 503-416-4722.