Alabama Medicaid Pharmacy
Short Acting Opiate Naïve Days' Supply Limit Override

FAX: (800) 748-0116	**Fax or Mail to**	**P.O. Box 3570**
Phone: (800) 748-0130	**KEPRO**	**Auburn, AL 36831-3210**

PATIENT INFORMATION

Patient Name_____ Patient Medicaid #_____

Patient DOB_____ Patient Phone # with Area Code_____

PRESCRIBER INFORMATION

Prescriber Name_____ NPI #_____ License #_____

Phone # with Area Code_____ Fax # with Area Code_____

Address (Optional)_____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I attest that all information included within this request is accurate. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescribing Provider Signature **Date**

DRUG/CLINICAL INFORMATION

Drug Requested_____ Strength_____ Drug Code_____

Quantity Requested_____ Days' Supply for Quantity Requested_____

Diagnosis/ICD-10 Code_____

Medical Justification_____

The questions below must be completed in order for requests to be considered for approval:

- Has the patient tried and failed at least one 5 day treatment trial with a non-opioid therapy in the past 14 days (ex. acetaminophen, nsaid, etc.)? ❒ Yes ❒ No If yes, indicate failed therapy, length of treatment trial, and date treatment ended:_____
- Has the prescriber reviewed the patient's PDMP prior to prescribing the requested medication? ❒ Yes ❒ No
- For female patients, has the patient been counseled on the risk of being/ becoming pregnant while on the requested medication, including the risk of neonatal abstinence syndrome (NAS)? ❒ Yes ❒ No
- Has the prescriber counseled the patient on the risk of concurrent use of the requested medication with benzodiazepines, sedative/hypnotics, or barbiturates? ❒ Yes ❒ No

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing Pharmacy_____ NPI #_____

Phone # with Area Code_____ Fax # with Area Code_____