BUPRENORPHINE AND BUPRENORPHINE/NALOXONE PRIOR AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

GENERAL INFORMATION

Patient Name			
Patient's Home Address			
City		State	Zip
Date of Birth (mm/dd/yyyy)	___ ___ / ___ ___ / ___ ___ ___ ___	Contract Number (include prefix)	

PRESCRIBER INFORMATION

Prescriber Name			
Practice Address			
City		State	Zip
Office Phone		Office Fax	
Practice Type ☐ PCP ☐ Specialty: _____		National Provider Indentifier (NPI)	

SECTION I: TREATMENT INFORMATION *(Please complete for all requests.)*

☐ Suboxone® ☐ Subutex® ☐ Bunavail® ☐ Zubsolv® Dose: _____ Directions: _____ Total Quantity: _____

Diagnosis Code: _____ Data 2000 Waiver ID ("X" DEA number): _____

Please complete the following for Subutex® requests only: Is the member pregnant? ☐ Yes ☐ No If yes, anticipated date of delivery: _____

Does the member have a documented allergic reaction or intolerance to naloxone? ☐ Yes ☐ No If yes, provide medical records documenting the reaction.

If you answered "No" to the two questions above, what is the medical necessity for prescribing Subutex®, rather than buprenorphine/naloxone, for this member.

SECTION II: *(Please complete this section for induction and stabilization authorization requests only.)*

Please check all applicable criteria and **attach supportive documentation** as to why continuation of therapy is necessary.

☐ Prescriber maintains current informed consent signed by the prescriber and patient.

☐ Prescriber has verified that the patient is currently not taking or will discontinue use of an opioid medication and/or addictive drug (including problematic alcohol and/or benzodiazepine use) prior to beginning treatment with requested agent.

☐ Prescriber attests that patient is currently enrolled in an ongoing outpatient drug addiction treatment/counseling program or has agreed to seek enrollment within the first 2 months of treatment with requested agent.

☐ Prescriber has attached an initial treatment plan including current baseline urine drug screen and documentation of medication history review.
Supportive documentation and clinical chart notes are required for review.

SECTION III: *(Please complete for maintenance therapy authorization requests only.)*

☐ Prescriber maintains current informed consent signed by the prescriber and patient.

☐ Physician certifies that they meet the requirements under DATA and have not exceeded the maximum number of patients allowed.

☐ Patient has been through induction and stabilization therapy and now seeks medication for maintenance therapy for treatment of a confirmed diagnosis of active opioid dependence. Consistent use of requested agent since previous authorization will be verified prior to approval.

☐ Prescriber has submitted a current treatment plan which includes a medication history review and the most recent drug screen indicating patient is free from illicit drug use. Supportive documentation and clinical chart notes are required for review.

☐ Prescriber has reviewed the patient's records in the states prescription drug monitoring program (PDMP) to confirm that the patient is not diverting medication.

☐ The patient continues to be enrolled in an outpatient drug addiction treatment /counseling program and has been compliant with all elements of the medical treatment plan or rationale has been submitted as to why patient no longer needs to continue drug addiction treatment.

☐ Documentation provided of anticipated duration of treatment, plan for drug taper or barriers to drug taper at this time.

PRESCRIBER SIGNATURE

I certify this information is complete and correct to the best of my knowledge.

Prescriber Signature _____ Date _____

Please attach any additional medical justification.

SUBMISSION INSTRUCTIONS

FAX You may fax the signedand completed form to Pharmacy Review at:
1-866-606-6021

MAIL *You may mail the signed and completed form to:*
Pharmacy Review
Post Office Box 529 • Auburn, AL 36381