**INITIAL Prior Authorization (PA) Form**

for oral buprenorphine

(formerly known as Subutex)

Suboxone (buprenorphine naloxone)

Please complete form and fax to **1-888-343-4232**

If the following information is not completed in full, correct, and/or legible,

the PA process may be delayed and could result in a denial.

#### Member Information

|  |  |
| --- | --- |
| Patient Name:  | Patient ID Number:  |
| Policy Holder Name:  | Patient Date of Birth:  | Sex: M or F |
| Address:  | Insurance Group Number:  |
| City/State/Zip:  | Phone (day): (night):  |

|  |  |  |
| --- | --- | --- |
| **Requested Medication:** | **Strength:** | **Quantity:** |
|  Suboxone  Buprenorphine |    |    |
|   |  |  |

#### Response is required to all questions. Please fill in information where it is requested.

#### Form will be returned if any question is left blank, which will delay authorization process.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 1. Is the medication requested being prescribed for the treatment of active opiate dependency and does the prescriber have a unique DEA number beginning with the letter X?

  **Yes,** proceed to criterion 2.  **No,** please forward medical records including diagnosis1. Has the prescriber obtained a waiver, as required by the Drug Addiction Treatment Act of 2000 (DATA 2000), which allows them to prescribe controlled substances for opiate dependency outside a hospital or clinical setting?

  **Yes,** please provide that unique DEA number and proceed to criterion 3.  **No,** no further information is needed.1. Is the prescriber’s practice site in one of the following states that do not have an operational controlled substance monitoring program: **Alaska, Arkansas, Delaware, District of Columbia, Georgia, Maryland, Missouri, Montana, Nebraska, New Hampshire, New Jersey, South Dakota, Washington** or **Wisconsin**?

  **Yes,** go to criterion 6.  **No,** go to criterion 4.1. Has the prescriber reviewed the patient’s prescription history on the state-controlled substance database within the last 30 days?

  **Yes,** go to criterion 5.  **No,** no further information is needed.1. What was the name of the last controlled substance medication filled for the patient and on what date was it filled? Once completed go to criterion 6.
2. Projected Treatment Plan :
* **Anticipated Induction/Stabilization Dose**

(Target less than or equal to 24mg/day) mg          **Start Date** * **Anticipated Step-Down Dose**

(Target less than or equal to 16mg/day) mg          **Start Date** * **Anticipated date medication will be discontinued:**
1. Is the requested agent Suboxone?

  **Yes**, no further information is required.  **No,** go to criterion 8.1. Please indicate why the patient cannot take Suboxone? Please check all that apply.

 Patient is transitioning from long-acting opioids  Treatment induction  Pregnancy (expected date of delivery ) Allergy, hypersensitivity, or intolerance to naloxone**NOTE:**  **If the answer is Allergy then the prescriber MUST include a copy of the patient’s medical record documenting the allergy, hypersensitivity or intolerance to naloxone).** Other (Please explain):   |  |  |  |

#### Physician Information

|  |  |
| --- | --- |
| Physician Name:  | Phone Number:  |
| Hospital/Clinic:  | Fax Number:  |
| Address:  | NPI Number:  |
| City/State/Zip:  | DEA Number:  |
| Name & Title of Person Submitting Form:  |

Revised 6/11