

**SUBOXONE, ZUBSOLV, & BUPRENORPHINE**  
Prior Authorization Form

- Standard Request (72 hours)  
 Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

**Demographics**

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

**Medication Information**

Medication	Strengths	Directions:	Quantity Dispensed:	Day Supply:
<input type="checkbox"/> Suboxone (Buprenorphine/ Naloxone)	<input type="checkbox"/> 2mg-0.5mg Sublingual Film <input type="checkbox"/> 4mg-1mg Sublingual Film <input type="checkbox"/> 8mg-2mg Sublingual Film <input type="checkbox"/> 12mg-3mg Sublingual Film			
<input type="checkbox"/> <b>Buprenorphine</b>	<input type="checkbox"/> 2mg Sublingual Tablet <input type="checkbox"/> 8mg Sublingual Tablet			
<input type="checkbox"/> Zubsolv ( <b>Buprenorphine</b> / <b>Naloxone</b> )	<input type="checkbox"/> 1.4mg-0.36mg Sublingual Tablet <input type="checkbox"/> 2.9mg-0.71mg Sublingual Tablet <input type="checkbox"/> 5.7mg-1.4mg Sublingual Tablet <input type="checkbox"/> 8.6mg-2.1mg Sublingual Tablet <input type="checkbox"/> 11.4mg-2.9mg Sublingual Tablet			
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

**Clinical Information**

Diagnosis:	Date Diagnosed:
<b>Is this an INITIAL authorization request?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If Yes, please submit the following: <input checked="" type="checkbox"/> Documentation of a recent <u>urine drug screen within the last 3 months</u> <input type="checkbox"/> Documentation enclosed <span style="margin-left: 150px;"><input type="checkbox"/> Documentation not available</span>	
<b>Is this a REAUTHORIZATION request?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If Yes, please submit the following: <input checked="" type="checkbox"/> Documentation indicating improvement in condition while on therapy. <input type="checkbox"/> Documentation enclosed <span style="margin-left: 150px;"><input type="checkbox"/> Documentation not available</span>	

**Please complete the following questions for Buprenorphine (Subutex) requests ONLY:**

Is the member pregnant?  Yes  No  
Does the member have intolerance to naloxone?  Yes  No  
✓ If yes, please provide chart documentation describing intolerance.  
 Documentation enclosed  Documentation not available

**Please complete the following questions for quantity limit exception requests:**

Does this requests exceed the quantity limit of 60 film strips/tablets per 30 days?  Yes  No  
✓ If yes, please provide **clinical rationale to support the need for dose requested exceeding the quantity limit of 60 film strips/tablets per 30 days.**  
 Documentation enclosed  Documentation not available

**Please provide any additional information which should be considered in the space below:**
