

SUBOXONE/SUBUTEX

PRIOR AUTHORIZATION REQUEST FORM

To Prescriber: Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:			
SECTION A - PATIENT INFORMATION			
First Name:		Last Name:	Member ID:
Address:			
City:	State:		Zip:
Phone:	DOB:	Allergies:	
Primary Insurance:	Policy #:	Group #:	
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION B - PHYSICIAN INFORMATION			
First Name:		Last Name:	M.D./D.O.
Address:			
City:	State:	Zip:	
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
SECTION C - MEDICAL INFORMATION			
Medication:		Strength:	
Directions for use:			
Diagnosis (Please be specific & provide as much information as possible):			ICD-9 CODE:
<ul style="list-style-type: none"> Does the patient have a DSM-TR diagnosis of opioid dependence? <i>(Please provide ICD-9 code above)</i> Does the prescriber have a 'X' waived DEA license to prescribe buprenorphine products, as per the requirements of the Drug Addiction Act of 2000? Is the patient currently receiving substance abuse rehabilitation services as part of their therapy for opioid dependence? Is this a new prescription or continuation of existing therapy? Is the prescribed buprenorphine products being used currently- <i>or will it be used in the future-</i> as a <u>pain management</u> medication? Has a drug urine screen been completed in the past 30 days? Has the patient relapsed? Did the drug urine screen results report negative for opiates and positive for buprenorphine? 			

Physician Signature: _____ **Date:** _____

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