



## Suboxone / Subutex

PATIENT NAME \_\_\_\_\_  
D.O.B. \_\_\_\_\_ MEMBER ID# \_\_\_\_\_  
DRUG REQUESTED: (Circle One) SUBOXONE or SUBUTEX FAX ATTENTION: \_\_\_\_\_  
DOSAGE and Sig. \_\_\_\_\_ DURATION \_\_\_\_\_  
PHYSICIAN (PLEASE PRINT) \_\_\_\_\_ PH# ( ) \_\_\_\_\_ FAX# ( ) \_\_\_\_\_  
PHYSICIAN ADDRESS \_\_\_\_\_  
\_\_\_\_\_

**\*Please Note:** ALL are required fields above

<< Additional Drug Specific forms are available at [UnisonHealthPlan.com](http://UnisonHealthPlan.com) >>

### Background Information Relevant to Requested Medication

- Intended Usage of Requested Agent: (Circle One)
  - OPIOID DETOXIFICATION
  - MAINTENANCE TREATMENT OF OPIATE DEPENDENCE
  - OTHER (PLEASE PRINT) \_\_\_\_\_
- Has this patient had a recent drug urine screen? Yes No
  - If yes, please note the following: (please attach copy of laboratory findings)  
Date of Urine Screen: \_\_\_\_\_  
Results: a. Opiate Positive b. Positive, other \_\_\_\_\_
- If the requested agent is Subutex, please indicate why Suboxone cannot be used? \_\_\_\_\_  
\_\_\_\_\_
- Does this patient have a social support system? Yes No
  - If yes, please explain the nature of this system \_\_\_\_\_  
\_\_\_\_\_
- Will this patient receive behavior modification counseling and psychological support? Yes No
  - If yes, please explain \_\_\_\_\_
- Will all agents used to treat any pain that occurs as a result of withdrawal or other underlying condition be non-opiate in nature? Yes No
  - Please explain \_\_\_\_\_

The purpose of this worksheet is to provide complete information regarding the physician's request for a non-formulary or prior authorization medication. It will be reviewed and notification of approval or denial will be given within 24 hours. Thank you.

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