Please complete ALL information below and fax your request to 1-888-671-5285

Oral Buprenorphine Products Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Opioid use disorder

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Quantity Limit and Day Supply Limit Requests:

What is the quantity requested per DAY? _____

Is the requested medication being used concurrently with comprehensive addiction care (this includes participation in nonpharmacological interventions such as drug abuse counseling, self-help programs, behavioral therapy, or other psychosocial services)? ❑ **Yes** ❑ **No**

Is there documentation that a urine toxicology screen has been conducted? ❑ **Yes** ❑ **No**

Does the requested dose and frequency exceed FDA approved dosing? ❑ **Yes** ❑ **No**

Is the requested dose and frequency supported by compendia? ❑ **Yes** ❑ **No**

Can the requested dose be achieved with commercially available dosage forms? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to lower doses? ❑ **Yes** ❑ **No**

For opioid regimens containing greater than 90 morphine milligram equivalents per day, answer the following:

Does the patient have pain associated with active cancer treatment, cancer not in remission, or sickle cell anemia? ❑ **Yes** ❑ **No**

Does the patient have severe, persistent chronic non-cancer pain? ❑ **Yes** ❑ **No**

If **yes**, document the diagnosis associated with the pain: _____

Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)? ❑ **Yes** ❑ **No**

Was the requested medication regimen prescribed by or in consultation with a pain management specialist within the last 6 months? ❑ **Yes** ❑ **No**

If **yes**, provide the name of the physician and date of last visit. Name: _____ Date: _____

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Select if the pain management specialist is board certified by one of the following below:

- ❑ American Board of Anesthesiology - Pain Management
- ❑ American Board of Psychiatry & Neurology - Pain Management
- ❑ American Board of Physical Medicine & Rehabilitation
- ❑ American Osteopathic Association - Pain Management

Select if the prescriber has evaluated the patient for the following therapies below:

- ❑ Physical therapy
- ❑ Psychotherapy
- ❑ Adjuvant medications specific to causative condition including but not limited to any of the following: Antidepressants, anticonvulsants, muscle relaxants, anti-inflammatory agents

Reauthorization

If this is a reauthorization request, answer the following:

Does the patient have pain associated with active cancer treatment, cancer not in remission, or sickle cell anemia? ❑ **Yes** ❑ **No**

Does the patient have severe, persistent chronic non-cancer pain? ❑ **Yes** ❑ **No**

If **yes**, document the diagnosis associated with the pain: _____

Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)? ❑ **Yes** ❑ **No**

Is there documentation that a urine drug screen (UDS) will be performed by the prescriber within 1 year of request? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.