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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This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of the Pharmacy Benefit Manager. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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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.

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