Buprenorphine Products Prior Authorization Form

Fax form to: 866-930-0019

No prior authorization requests for Buprenorphine-containing products will be taken by phone.

Member Information	**Name:**	**DOB:**
	ID:	**Sex:** ☐ M ☐ F
	Address: **City, State, Zip:**	**Phone:**
Prescriber Information	**Name:**	
	Office Contact:	**XDEA:**
	NPI: **Address:** **City, State, Zip:** **Phone:**	**Fax:**
	Diagnosis:	**ICD-10:**

Product name:

___ Buprenorphine 2 mg tablet **____ Buprenorphine 8 mg tablet**

___ Buprenorphine/naloxone tablets 2 mg/0.5 mg **____ Buprenorphine/naloxone tablets 8 mg/2 mg**

*****Other** _____

*****(Any request for BRANDED product will require a MedWatch form, copy of receipt of submission to MedWatch, and chart note documenting the adverse reaction, allergic reaction, or therapeutic failure.)**

Dose & Frequency:	**Quantity:**	**Daily Dose:**

Buprenorphine (without naloxone) Tablet Requests Only (Must meet clinical criteria AND ONE of the following)

Check One: ☐ Member Is Pregnant ☐ Up to 1st 7 Days of induction to therapy ☐ Hypersensitivity to Naloxone

Induction Requests Only	1. Prescriber certifies they are treating the patient for opioid use disorder through the member's benefit/health plan and billing the plan for the services, and member has signed an informed consent. _____ Yes _____ No 2. Is this an induction request? ____Yes If yes, Date of Induction_____ ____ No (Please skip to Continuation Request Section) 3. Prescriber certifies that the patient is being referred or already started receiving behavioral and psychosocial therapy services. _____ Yes _____ No 4. Prescriber certifies that the required state controlled substance report (OARRS, KASPER, etc.) has been reviewed no earlier than 2 days prior to the date of this request. ____Yes ___No 5. For patients with concurrent behavior health disorders, the prescriber certifies referral for mental health assessment and/or treatment as indicated. _____ Yes _____ No
Continuation Requests Only	1. Prescriber certifies they are treating the patient for opioid use disorder through the member's benefit/health plan and billing the plan for the services and member has assigned informed consent. ____ Yes ___ No 2. Prescriber certifies that the required state controlled substance report (OARRS, KASPER, etc.) has been reviewed no earlier than 2 days prior to the date of this request. _____Yes _____ No (Attach documentation of reason for any opioid, stimulant or benzodiazepine listed on the report.) 3. The prescriber certifies that the patient has at least one negative urine test for **opiates** within last 3 months. _____ Yes _____ No 4. The prescriber certifies that the patient has at least one positive urine test for **Buprenorphine and/or Norbuprenorphine** within last 3 months. _____ Yes _____ No If no, the provider certifies that regular medication compliance checks occur and there have been no abnormal findings in the pill count. _____ Yes _____ No 5. The prescriber certifies that he/she has completed an evaluation and has documented clinical reasoning for continuation of therapy. _____ Yes _____ No _____ n/a

I attest, by signature, that the above information is true and accurate to the best of my knowledge and has been documented appropriately in the member's medical records.

Prescriber Signature	Date