



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: <input type="checkbox"/> M <input type="checkbox"/> F
	Address: City, State, Zip:	Phone:
Prescriber Information	Name:	
	Office Contact:	XDEA:
	NPI:	Fax:
	Address: City, State, Zip:	
	Phone:	
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:
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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
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