CareSource
P.O. Box 8738, Dayton, OH 45401-8738

Non-preferred Buprenorphine/Naloxone
(Suboxone Film, Zubsolv, Bunavail)

Pharmacy Prior Authorization Request Form

RETURN FAX TO: 866-930-0019

Instructions:
This form is to be used by participating providers to obtain coverage for non-preferred formulations of buprenorphine/naloxone. Please complete this form and fax it to CareSource at 866-930-0019. If you have any questions regarding this process, please contact CareSource Customer Service at 844-607-2831. Note: Illegible requests or incomplete requests without medical justification or previous medications listed will be considered INCOMPLETE.

Member/Provider Information:

CareSource Member's Name:	**Provider's Name:**
CareSource Member's ID #:	**Provider's Specialty:**
CareSource Member's DOB (mm-dd-yy):	**Provider's DEA #:** | **Provider's NPI #:**
Pharmacy used by CareSource Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**

Clinical Information:

Requested Drug:	**Quantity Requested:**
Strength and Dosage Regimen Requested:	**Date Requested:**

Documentation of Medical Necessity:

Did the patient have a hypersensitivity reaction to an inactive ingredient in generic buprenorphine/naloxone SL tablets (hypersensitivity reaction must be documented in submitted chart notes)?

☐ Yes ☐ No

OR

Did the patient fail at least 28 days of treatment with generic buprenorphine/naloxone SL tablets in the previous 120 days due to therapeutic failure or adverse outcome that could not be addressed with dose adjustment?

☐ Yes ☐ No

Prior authorization is contingent upon your submission to the FDA of a completed MedWatch form which describes the therapeutic failure or adverse outcome(s) experienced by the patient with generic buprenorphine/naloxone SL tablets.

Is proof of submission of the MedWatch form to the FDA attached to this request for prior authorization?

☐ Yes ☐ No

MedWatch forms can be downloaded at the following address:
http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

Please attach additional information which may indicate why the ***non-preferred*** medication is being requested for this patient.

Provider signature Date

*In order to process this request, please complete all boxes completely. CareSource will review and issue a decision within 24 hours of the original receipt of a pharmacy prior authorization request. This facsimile and any attached documents are confidential and are intended for the use of the individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at 1-844-607-2831.