

Suboxone/Buprenorphine (Subutex)

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Member Name:	UPMC Health Plan ID Number:	DOB:	Age:
Drug Requested: <input type="checkbox"/> Suboxone film <input type="checkbox"/> Buprenorphine tablet	<input type="checkbox"/> Suboxone tablet	Strength: <input type="checkbox"/> 2 mg <input type="checkbox"/> 8 mg	Frequency: Qty Dispensed:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication <input type="checkbox"/> Restart	If ongoing, provide date started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	
Please complete the following questions for ALL requests			
Does the prescribing physician have a unique identification number issued by the DEA certifying prescribing authority for buprenorphine?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please submit documentation of a recent urine drug screen within the last 3 months. Please include date of test. Testing should include licit and illicit drugs with the potential for abuse and include oxycodone.			
<input type="checkbox"/> Documentation enclosed		<input type="checkbox"/> Documentation not available	
Please provide the names of any controlled substance medications that are currently prescribed to the member:			
Medication Name	Strength/Frequency	Dates of Therapy	
For reauthorization requests, please provide clinical rationale to support continuation of therapy if urine drug screen is positive for opiates and/or negative for Suboxone/Buprenorphine.			
Compliance with Suboxone/Buprenorphine is required. Pharmacy claims will be reviewed. If applicable, please provide clinical rationale to support continuation of Suboxone/Buprenorphine despite apparent non-compliance.			
Is the member currently taking a benzodiazepine?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, will there be an attempt to taper off benzodiazepine therapy?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please be sure to complete and include the 2 nd page of this form			

Suboxone/Buprenorphine (Subutex)

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Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:
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Please be sure to complete and include this page with the 1st page of this form

Is this an INITIAL authorization request?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If Yes, please submit the following:

- Documentation of an initial evaluation or scheduled appointment by a licensed Drug and Alcohol provider to determine the recommended level of care.
- Documentation of referral to or enrollment in formal behavioral health counseling and/or substance abuse counseling. Initial treatment must be performed with a licensed Drug and Alcohol or a behavioral health provider that is consistent with the level of care recommended at the initial authorization.

Documentation enclosed Documentation not available

Is this a REAUTHORIZATION request, please submit the following?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If Yes, please submit the following:

- Documentation showing the member is participating in at least monthly formal behavioral health counseling, substance abuse counseling, or an addiction recovery program.

Documentation enclosed Documentation not available

Please complete the following questions for Buprenorphine (Subutex) requests ONLY

Is the member pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Does the member have an intolerance to naloxone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please provide chart documentation describing intolerance.

Documentation enclosed
 Documentation not available

Please complete the following questions for Suboxone TABLET requests for UPMC for *You* members ONLY

Please submit documentation showing why the member cannot use the Suboxone film. Please include clinical information showing an adequate trial of Suboxone film with an inadequate response or intolerance.

Documentation enclosed Documentation not available

Please provide clinical rationale to support the need for dose requests exceeding the quantity limit of 60 tablets/film strips per 30 days:

Please provide any additional information which should be considered in the space below:
