UPMC Health Plan

Suboxone, Zubsolv, Bunavail, & Subutex

Prior Authorization Form for UPMC Health Plan Commercial, UPMC *for You*, and UPMC *for Kids* members

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: 1-800-979-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:
- ☐ Suboxone tablet
- ☐ Suboxone film
- ☐ Bunavail film
- ☐ Zubsolv tablet
- ☐ Subutex tablet
- ☐ Brand
- ☐ Generic

Strength:
- ☐ 2-0.5mg
- ☐ 4-1mg
- ☐ 8-2mg
- ☐ 12-3mg
- ☐ 2mg
- ☐ 8mg
- ☐ 1.4-0.36mg
- ☐ 5.7-1.4mg
- ☐ 2.1-0.3mg
- ☐ 4.2-0.7mg
- ☐ 6.3-1mg

Frequency:

Qty Dispensed:

Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

☐ New medication ☐ Ongoing medication ☐ Restart	**If ongoing, provide date started:**	**If medication is ongoing, did the member show improvement while on therapy?**	☐ Yes ☐ 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 Subutex?	☐ Yes ☐ 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.

☐ Documentation enclosed ☐ 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/Zubsolv/Subutex.

Compliance with Suboxone/Zubsolv/Subutex is required. Pharmacy claims will be reviewed. If applicable, please provide clinical rationale to support continuation of Suboxone/Zubsolv/Subutex despite apparent noncompliance.

Please be sure to complete and include the 2nd and 3rd pages of this form.

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Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include this page with the 1st and 3rd pages of this form.

Is the member currently taking a benzodiazepine? ☐ **Yes** ☐ **No**

If yes, will there be an attempt to taper off benzodiazepine therapy? ☐ **Yes** ☐ **No**

If no, please provide clinical rationale for continuation while on therapy with buprenorphine:

For an INITIAL or RESTART authorization request:

Please provide documentation of an initial evaluation or scheduled appointment by a licensed Drug and Alcohol (D&A) provider to determine the recommended level of care. Please include the following:

- **If referred, please provide date of appointment:** _____
- **If evaluation completed, please provide the following:** _____
  - **Name of licensed D&A Provider who completed the assessment:** _____
  - **Date of initial intake or evaluation:** _____
  - **The recommended level of care at the initial evaluation (including type of counseling and frequency of sessions):** _____
- **If already attending counseling, please provide the following:**
  - **Name of licensed D&A or Behavioral Health Provider who is providing counseling:** _____
  - **Dates of attendance in the recommended level of care:** _____
- **Is the member adherence to the recommended level of care?** ☐ **Yes** ☐ **No**

If above information is not available, please provide a reason:

For a REAUTHORIZATION request:

If the D&A evaluation was not provided for the for previous authorization, please include the following:

- **Name of licensed D&A Provider who completed the assessment:** _____
- **Date of initial intake or evaluation:** _____
- **The recommended level of care at the initial evaluation (including type of counseling and frequency of sessions:** _____
- **Name of licensed D&A or Behavioral Health Provider who is providing counseling:** _____

For all requests, please provide the following:

- **Dates of attendance in the recommended level of care:** _____
- **Is the member adherence to the recommended level of care?** ☐ **Yes** ☐ **No**

If above information is not available, please provide a reason:

Please provide clinical rationale to support the need for dose requests exceeding the quantity limit:

Please be sure to complete and include the 1st and 3rd pages of this form.

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Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include this page with the 1st and 2nd pages of this form.

Please complete the following questions for Subutex requests ONLY.

Is the member pregnant?	☐ **Yes**	☐ **No**
Does the member have intolerance to naloxone?	☐ **Yes**	☐ **No**

If yes, please provide chart documentation describing intolerance.

☐ **Documentation enclosed** ☐ **Documentation not available**

Please complete the following questions for Suboxone TABLET and Bunavail FILM requests for UPMC for *You* members ONLY.

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

☐ **Documentation enclosed** ☐ **Documentation not available**

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