

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: <input type="checkbox"/> Suboxone tablet <input type="checkbox"/> Suboxone film <input type="checkbox"/> Zubsolv tablet <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength: <input type="checkbox"/> 2-0.5mg <input type="checkbox"/> 2mg <input type="checkbox"/> 2.1-0.3mg <input type="checkbox"/> 4-1mg <input type="checkbox"/> 8mg <input type="checkbox"/> 4.2-0.7mg <input type="checkbox"/> 8-2mg <input type="checkbox"/> 1.4-0.36mg <input type="checkbox"/> 6.3-1mg <input type="checkbox"/> 12-3mg <input type="checkbox"/> 5.7-1.4mg	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 Subutex?	<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/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.

UPMC Health Plan

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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.

