UPMC Health Plan

Suboxone, Zubsolv, & Subutex

Prior Authorization Form for UPMC *for Life*, UPMC *for You Advantage*, UPMC *for Life Options*, and UPMC *for Community Care* Medicare 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:	Strength:	Frequency:	Qty Dispensed:
☐ Suboxone film ☐ Subutex tablet ☐ Suboxone tablet ☐ Zubsolv tablet ☐ Brand ☐ Generic	☐ 2-0.5mg ☐ 2mg ☐ 4-1mg ☐ 8mg ☐ 8-2mg ☐ 1.4-0.36mg ☐ 12-3mg ☐ 5.7-1.4mg		

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 page of this form.

UPMC Health Plan

Suboxone, Zubsolv, & Subutex
Page 2

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

Please be sure to complete and include this page with the 1st page 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
Is this an INITIAL authorization request?	☐Yes ☐No

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?	☐Yes ☐No

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 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 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 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: