Premier Health Plan

Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

SUBOXONE, SUBUTEX & BUNAVAIL
Prior Authorization Form

☐ Standard Request ☐ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

		Directions:	Quantity Dispensed:	Day Supply:
☐ Suboxone (Buprenorphine Hydrochloride, Naloxone)	☐ 2mg-0.5mg Sublingual Film ☐ 4mg-1mg Sublingual Film ☐ 8mg-2mg Sublingual Film ☐ 12mg-3mg Sublingual Film ☐ 2mg-0.5mg Sublingual Tablet ☐ 8mg-2mg Sublingual Tablet			
☐ Subutex (Buprenorphine)	☐ 2mg Sublingual Tablet ☐ 8mg Sublingual Tablet			
☐ New medication ☐ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Clinical Information

Diagnosis:	Date Diagnosed:

Does the prescribing physician have a unique identification number issued by the DEA certifying prescribing authority for buprenorphine? ☐ Yes ☐ No

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

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

Please provide the names of any controlled medications that are currently prescribed to the member:

Medication Name	Strength/Frequency	Dates of Therapy

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

The information contained in this document is confidential. The information is only intended for the use of the individual or entity named above. If you are not the intended recipient of this information, you are hereby notified that any disclosure, copying, or distribution of this information is strictly prohibited. If you have received this message in error please immediately notify the sender by telephone listed above to arrange for its return.

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

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.
- ✓ 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.

☐ Documentation enclosed ☐ Documentation not available

Please complete the following questions for Buprenorphine (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 ONLY

Does this requests exceed the quantity limit of 60 tablets/film strips per 30 days? ☐ Yes ☐ No

- ✓ If yes, please provide **clinical rationale to support the need for dose requested exceeding the quantity limit of 60 tablets/film strips per 30 days.**
- ✓ 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 any additional information which should be considered in the space below:

The information contained in this document is confidential. The information is only intended for the use of the individual or entity named above. If you are not the intended recipient of this information, you are hereby notified that any disclosure, copying, or distribution of this information is strictly prohibited. If you have received this message in error please immediately notify the sender by telephone listed above to arrange for its return.