Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

SUBOXONE, ZUBSOLV, & BUPRENORPHINE
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

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

□ Suboxone (Buprenorphine/ Naloxone)	□ 2mg-0.5mg Sublingual Film □ 4mg-1mg Sublingual Film □ 8mg-2mg Sublingual Film □ 12mg-3mg Sublingual Film	Directions:	Quantity Dispensed:	Day Supply:
□ **Buprenorphine**	□ 2mg Sublingual Tablet □ 8mg Sublingual Tablet			
□ Zubsolv (**Buprenorphine / Naloxone**)	□ 1.4mg-0.36mg Sublingual Tablet □ 2.9mg-0.71mg Sublingual Tablet □ 5.7mg-1.4mg Sublingual Tablet □ 8.6mg-2.1mg Sublingual Tablet □ 11.4mg-2.9mg 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:

Is this an INITIAL authorization request? □ Yes □ No

If Yes, please submit the following:

✓ Documentation of a recent *urine drug screen within the last 3 months*

□ Documentation enclosed □ Documentation not available

Is this a REAUTHORIZATION request? □ Yes □ No

If Yes, please submit the following:

✓ Documentation indicating improvement in condition while on therapy.

□ 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 quantity limit exception requests:

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

- ✓ If yes, please provide **clinical rationale to support the need for dose requested exceeding the quantity limit of 60 film strips/tablets per 30 days.**

☐ Documentation enclosed ☐ Documentation not available

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