

Suboxone®/Subutex® Pharmacy Prior Authorization Form

Confidential Information



Member Name:		
Member DOB:	Member ID #:	
Provider Name:		Specialty:
Telephone:	Fax:	DEA # (with "x"):
Provider Address:		Provider NPI#:
City:	State:	Zip:
Drug Requested: Suboxone®/Subutex®		
Directions: <input type="checkbox"/> 2mg <input type="checkbox"/> 8mg ___ tablets ___ time(s) per day		
Treatment Plan/Anticipated length of therapy:		

List Diagnosis/ICD-9 code (NOTE: ICD-9 code 304.0x, 304.7x,305.5x required for approval):

Initial Request	Renewal Request
<p>If the criteria below are met, an initial maximum of 6 months of Suboxone® (1 month dispensed at a time), or up to a total of 4 weeks of Subutex®, will be authorized, depending upon the request of the physician. If the criteria are not met, physician review will be necessary to determine whether other factors, such as age, co-morbidities, social situation, or prior treatment considerations, would support medical necessity for the initiation or re-initiation of Suboxone®/Subutex®.</p> <p>Please check all applicable criteria (explain unchecked boxes on 2nd page)</p> <ul style="list-style-type: none"><input type="checkbox"/> Member age ≥16 years old.<input type="checkbox"/> DEA Number assigned allowing prescribing of Suboxone® (Place Suboxone DEA # in Confidential Information section above).<input type="checkbox"/> The risks/benefits of using Suboxone® have been explained to the member.<input type="checkbox"/> Prescriber performs monthly KASPER reports.<input type="checkbox"/> If pregnant, explain clinical reason alternative opioid dependence treatment using methadone is being bypassed: _____ _____<input type="checkbox"/> The member is participating in formal counseling for addiction. (Dates of counseling*? _____) <p>List co-occurring conditions if any: _____ _____</p> <p>Is psychiatric condition stabilized and/or treated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable</p> <p>List number of prior attempts to treat opiate addiction with Suboxone® within the past 12 months: _____</p>	<p>If the criteria below are met, an additional 6 months of Suboxone® will be authorized (1 month dispensed at a time). If the criteria are not met, physician review will be necessary to determine whether other factors support medical necessity for continuation of Suboxone®.</p> <p>Please check all applicable criteria (explain unchecked boxes on 2nd page)</p> <ul style="list-style-type: none"><input type="checkbox"/> Member has consistently been taking Suboxone. (How long? _____) <i>If not, provide written explanation on page 2 to support why Suboxone® should be continued despite noncompliance.</i><input type="checkbox"/> Member has been off opiates. (How long? _____)<input type="checkbox"/> Prescriber has performed monthly KASPER report.<input type="checkbox"/> Member is actively involved in counseling for addiction. <p>Member is receiving behavioral health care for co-existing behavioral health disorders. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable</p>

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**There is an expectation of four initial counseling sessions within the first month of Suboxone® use.*

