Zubsolv Prior Authorization Request Form
FAX to: WellCare Pharmacy 1-866-825-2884

Member Name		Prescriber Full Name/Specialty	
WellCare ID #	Date of Birth	DEA# (including X)	NPI #
Member's Telephone #		Office Address	
Primary Diagnosis		Contact	
Quantity		Office Phone #	
Frequency		Office Fax #	

*****Form must be completed, signed and submitted by a physician with a Drug Addiction Treatment Act (DATA) waiver (UIN #)***

Drug Requested (include strength & dosage form)*:_______________________________________

*Doses above 17.1 mg/4.2 mg buprenorphine/naloxone per day will NOT be approved.
Approval duration of therapy is 6 months (doses less than or equal to 11.4 mg/2.9 mg buprenorphine/naloxone per day) or 3 months (doses above 11.4 mg/2.9 mg buprenorphine/naloxone per day).

Start date of this PA: ______________

1. ☐ **New Start** ☐ **Reauthorization (established patient)**
   If new start, a taper schedule showing dose reduction and time frame for tapering is required.
   If established patient, a copy of the most current urine drug screen is required. *For positive urine drug screens or claims history suggestive of concurrent opioid/illicit drug use, the physician must document acknowledgment of opioid/illicit drug usage and plan to address its usage. Appropriate acknowledgement may include adjustment of dose strength or frequency of office visits, increased screening, or a consultation with a specialist.*

2. **Psychosocial Counseling – Attach medical notes regarding treatment plan and documentation of compliance and psychosocial counseling.**
   a. Date of last psychosocial counseling session: ____________________________________
   b. Has patient been compliant with all sessions? [ ] Yes [ ] No
   Please provide plan for method and dates (next 3) of psychosocial counseling going forward:
   a. Method: ____
   b. Dates: (1) ________________ (2) __________________ (3) ______________________

3. Does patient currently abuse alcohol? [ ] Yes [ ] No

4. Has patient taken opioids in the past 30 days? [ ] Yes [ ] No
   a. If yes, please state reason for opioid use: ______________________________________
   b. If yes, has patient experienced a relapse in disease? [ ] Yes [ ] No

5. **Taper trial (documentation of attempts to taper including schedule, dose, duration and outcome) is required for reauthorization.** ____

Physician Signature ____ **Date** _________________
****** I certify that I have a ***Drug Addiction Treatment Act (DATA) waiver.***

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