



Opioid Dependence Therapy Agents PA Request Form

Use this form to request coverage for Bunavail, buprenorphine/naloxone tablets, Zubsolv, and buprenorphine tablets

Suboxone Film and Sublocade do not require Prior Approval

Beneficiary Information

1. Beneficiary Last Name: 2. First Name: 3. Beneficiary ID #: 4. Beneficiary Date of Birth: 5. Recipient Gender:

Prescriber Information

6. Prescribing Provider NPI#: 6a. Requester Contact Information. Name: Phone #:

Please answer 7a, 7b and 7c for all PA requests

- 7a. Does the beneficiary have a diagnosis of Opioid Dependence? Yes No
7b. What is the total daily dose of the opioid dependence therapy agent being requested? mg/day
7c. Has the Provider reviewed the Controlled Substances Reporting System Database prior to writing the prescription to ensure that concomitant opioid or use is not occurring? Yes No

Bunavail, Zubsolv, buprenorphine/naloxone tablets (questions 8-10)

8. Name of Medication requested: 8a. Strength: 8b. Quantity per 30 days
8c. Requested Duration
9. Has the beneficiary tried and failed on Suboxone Film? Yes No
10. If the beneficiary has not tried and failed on Suboxone Film, please describe the clinical reason the beneficiary cannot use Suboxone Film.

buprenorphine tablets (questions 11-16a)

11. Strength: 11a. Quantity per 30 days 11b. Requested Duration
12. Is the beneficiary unable to take Suboxone Film? Yes No
13. Is the beneficiary pregnant? Yes No 13a. Is documentation attached? Yes No
14. If the beneficiary is pregnant, what is the estimated due date? (approvals can be granted for up to 9 months)
15. Is the beneficiary nursing? Yes No (approvals can be granted in 2 month intervals)
16. Does the beneficiary have an allergy to naloxone with rashes, hives, pruritus, bronchospasm, angioneurotic edema, or anaphylactic shock? Yes No 16a. Is documentation attached? Yes No

Signature of Prescriber: Date:

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318