

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of Opioid Use Disorder as defined by DSM 5?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the prescriber review the Virginia PMP before the initiation of therapy and document fill date of last opioid RX and date of the last benzodiazepine RX (if the patient is using RX opioids and/or benzodiazepines)? <i>List date of last opioid and benzodiazepine:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient taking any of the following medications concurrently: benzodiazepines, tramadol (Ultram), carisoprodol (Soma), other opiates, or sedative hypnotics? <i>If yes, list medications patient is taking:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the provider documented extenuating circumstances that necessitate the co-prescribing of these medications AND documented in the medical record a tapering plan to achieve the lowest possible effective doses of these medications? <i>If yes, list extenuating circumstances and documented taper plan:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	If requesting a non-preferred medication, is there a reason why the patient cannot be prescribed a preferred agent? NOTE: A completed FDA MedWatch form is required to be attached for adverse reactions to combination products. <i>If yes, list reason:</i>

BUPRENORPHINE TABS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient pregnant?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation of a positive pregnancy test along with expected date of delivery? <i>If yes, list expected date of delivery:</i>

QUANTITY LIMITS

NOTE: The equivalent dose of Suboxone 16/4 mg per day is as follows: Bunavail = 8.4/1.4 mg, Zubsolv = 11.4/2.9 mg. The equivalent dose of Suboxone 24/6 mg/day is as follows: Bunavail = 12.6/2 mg, Zubsolv = 17.2/4.2 mg.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the provider submitted clinical rationale including documentation of why this higher dose is medically necessary? <i>If yes, list rationale:</i>
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CONTINUATION OF THERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the prescriber reviewed the Virginia PMP on the date of the request for Maintenance of therapy? <i>If yes, list date reviewed:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the prescriber checking random urine drug screens as part of the treatment?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the random urine screens check for buprenorphine, norbuprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates?

Provider Signature: _____ **Date:** _____

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