UnitedHealthcare Community Plan

Suboxone - Arizona
Prior Authorization Request Form

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: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have a DSM-V-TR diagnosis of opioid use disorder?**
□ Yes □ No	**Does the prescriber attest that the patient is currently receiving substance abuse rehabilitation services as part of their therapy for opioid dependence?**
□ Yes □ No	**Does the prescriber have a 'X' waivered DEA license to prescribe buprenorphine products, as per the requirements of the Drug Addiction Treatment Act of 2000?**
□ Yes □ No	**If not requesting Suboxone, is there a reason or special circumstance why the patient cannot use the preferred FILM formulation?** *If yes, list reason:*
REQUESTS EXCEEDING QUANTITY LIMIT	
(Please Note: The preferred doses and formulation of Suboxone are the 2/0.5 mg, 4/1 mg, 8/2 mg, and 12/3 mg FILMS) *(Please Note: The preferred dose for initial requests are 24mg/day, continuation requests are 16mg/day)*	
□ Yes □ No	**Has the physician provided rationale for needing to exceed the buprenorphine daily limit?** *If yes, List rationale:*
CONTINUATION OF THERAPY	
□ Yes □ No	**Has the patient been prescribed a buprenorphine product for the purpose of opioid use disorder maintenance therapy?**
□ Yes □ No	**Has the prescriber documented that the patient has relapsed?**
□ Yes □ No	**Does the provider attest that the patient continues to receive urine drug screenings as part of their therapy for opioid dependence?**
□ Yes □ No	**Does the prescriber attest that the patient continues to receive substance abuse rehabilitation services as part of their therapy for opioid dependence?**

Provider Signature: _____ Date: _____