

Suboxone / Subutex - New York EPP **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 Inform | nation | | | | | | | |
|--|---------------------------------|------------|-----------------|------------------------------------|-------------|--------------|--|--|
| First Name: | Last Name: | | | Memb | Member ID: | | | |
| Address: | | | | | | | | |
| City: | State: | | | ZIP C | ZIP Code: | | | |
| Phone: | DOB: | | | Allergi | Allergies: | | | |
| Primary Insurance Information | (if any): | | | | I | | | |
| Is the requested medication | n: □ New or □ | Continuati | ion of Thera | py? If continuation | n, list sta | rt date: _ | _ | |
| Is this patient currently ho | spitalized? | Yes □ No | If recently | discharged, list di | scharge | date: | | |
| Section B - Provider Inforn | nation | | | | | | | |
| First Name: | | | Last Name: | | | M.D./D.O. | | |
| Address: | | | City: | | State: | | ZIP code: | |
| Phone: | Fax: | | NPI #: Spe | | | pecialty: | | |
| Office Contact Name / Fax atte | ntion to: | | • | | • | | | |
| Section C - Medical Inform | ation | | | | | | | |
| Medication: | | | | | | Strength: | | |
| Directions for use: | | | | | | Quantity: | | |
| Diagnosis (Please be specific & provide as much information as possible): | | | | | | ICD-10 CODE: | | |
| | • | | . ac pecc.s.c). | | | 100-100 | ODL. | |
| Is this member pregnant? | • | | | member's due date? | | CD-10 C | <u> </u> | |
| | Yes □ No | | | | | | | |
| Is this member pregnant? | Yes □ No | If yes, | | | | Reaso | n for failure / | |
| Is this member pregnant? | Yes □ No cation Trials | If yes, | what is this | member's due date? | | Reaso | n for failure / | |
| Is this member pregnant? | Yes □ No cation Trials | If yes, | what is this | member's due date? | | Reaso | n for failure / | |
| Is this member pregnant? | Yes □ No cation Trials | If yes, | what is this | member's due date? | | Reaso | n for failure / | |
| Is this member pregnant? | Yes □ No cation Trials | If yes, | what is this | member's due date? | | Reaso | n for failure / | |
| Is this member pregnant? Section D – Previous Medication Name | Yes □ No cation Trials Strength | If yes, | what is this | nember's due date? Dates of Thera | ару | Reason | n for failure / ontinuation | |
| Is this member pregnant? Section D – Previous Medication Name Medication Name Section E – Additional info | Yes □ No cation Trials Strength | If yes, | what is this | nember's due date? Dates of Thera | would no | Reason disco | n for failure / ontinuation e patient's needs: | |
| Is this member pregnant? Section D – Previous Medication Name Medication Name Section E – Additional info | Yes □ No cation Trials Strength | If yes, | what is this | Dates of Thera | would no | Reason disco | n for failure / ontinuation e patient's needs: | |
| Is this member pregnant? Section D – Previous Medication Name Medication Name Section E – Additional info | Yes □ No cation Trials Strength | If yes, | what is this | Dates of Thera | would no | Reason disco | n for failure / ontinuation e patient's needs: | |
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| Member First | name: | Member Last name: | Member DOB: | | | | |
|---|---|-------------------|-------------|--|--|--|--|
| Clinical and Drug Specific Information | | | | | | | |
| ALL REQUESTS | | | | | | | |
| Please Note: The equivalent dose per day of Bunavail is 12.6/2 mg (2 films of the 6/3/1.0mg). The equivalent dose per day of Zubsolv is 17.2/4.2mg (2 tabs of the 8.6/2.1mg). | | | | | | | |
| □ Yes □ No | Does the patient have a DSM-V-TR diagnosis of opioid use disorder? | | | | | | |
| □ Yes □ No | Is there a reason or special circumstance why the patient cannot use BOTH of the following? □ Buprenorphine/naloxone sublingual film □ Buprenorphine/naloxone sublingual tablet If yes, list reason or special circumstance: | | | | | | |
| □ Yes □ No | Does the requested quantity exceed 24mg of buprenorphine daily or equivalent dosing of an alternative medication? | | | | | | |
| CONTINUATION OF THERAPY | | | | | | | |
| □ Yes □ No | Has the patient been prescribed a buprenorphine product for the purpose of opioid use disorder maintenance therapy? | | | | | | |
| Provider Signature: Date: | | | | | | | |

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