

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 at [www.uhcprovider.com](http://www.uhcprovider.com) 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**

**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 8.6/2.1 mg).

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a DSM-V-TR diagnosis of opioid use disorder?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there a reason or special circumstance why the patient cannot use BOTH of the following?</b> <input type="checkbox"/> Buprenorphine/naloxone sublingual film <input type="checkbox"/> Buprenorphine/naloxone sublingual tablet <i>If yes, list reason or special circumstance:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the requested quantity exceed 24mg of buprenorphine daily or equivalent dosing of an alternative medication?</b>
<b>CONTINUATION OF THERAPY</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has the patient been prescribed a buprenorphine product for the purpose of opioid use disorder maintenance therapy?</b>

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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