

## Oral Buprenorphine Products Prior Authorization Request Form (Page 1 of 2)

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<b>Member Information</b> (required)			<b>Provider Information</b> (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

<b>Medication Information</b> (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

<b>Clinical Information</b> (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Opioid use disorder	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<b>Quantity Limit and Day Supply Limit Requests:</b>
What is the quantity requested per DAY? _____
Is the requested medication being used concurrently with comprehensive addiction care (this includes participation in nonpharmacological interventions such as drug abuse counseling, self-help programs, behavioral therapy, or other psychosocial services)? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Is there documentation that a urine toxicology screen has been conducted? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Does the requested dose and frequency exceed FDA approved dosing? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Is the requested dose and frequency supported by compendia? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Can the requested dose be achieved with commercially available dosage forms? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has the patient had an inadequate response to lower doses? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

<b>For opioid regimens containing greater than 90 morphine milligram equivalents per day, answer the following:</b>
Does the patient have pain associated with active cancer treatment, cancer not in remission, or sickle cell anemia? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Does the patient have severe, persistent chronic non-cancer pain? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
If <b>yes</b> , document the diagnosis associated with the pain: _____
Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Was the requested medication regimen prescribed by or in consultation with a pain management specialist within the last 6 months? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
If <b>yes</b> , provide the name of the physician and date of last visit. Name: _____ Date: _____

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Select if the pain management specialist is board certified by one of the following below:

- American Board of Anesthesiology - Pain Management
- American Board of Psychiatry & Neurology - Pain Management
- American Board of Physical Medicine & Rehabilitation
- American Osteopathic Association - Pain Management

Select if the prescriber has evaluated the patient for the following therapies below:

- Physical therapy
- Psychotherapy
- Adjuvant medications specific to causative condition including but not limited to any of the following: Antidepressants, anticonvulsants, muscle relaxants, anti-inflammatory agents

## Reauthorization

**If this is a reauthorization request, answer the following:**

Does the patient have pain associated with active cancer treatment, cancer not in remission, or sickle cell anemia?  Yes  No

Does the patient have severe, persistent chronic non-cancer pain?  Yes  No

If **yes**, document the diagnosis associated with the pain: \_\_\_\_\_

Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)?  Yes  No

Is there documentation that a urine drug screen (UDS) will be performed by the prescriber within 1 year of request?  Yes  No

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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Please note: This request may be denied unless all required information is received.