

**PRIOR AUTHORIZATION REQUEST FORM**
**OPIOID DEPENDENCE AGENTS**

buprenorphine, buprenorphine-naloxone, Bunavail®, Suboxone®, Zubsolv®

**For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.**

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

**Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.**

**Preferred:**  buprenorphine-naloxone sublingual tablets,  buprenorphine-naloxone sublingual film  buprenorphine (generic) sublingual tablets

**Non-preferred:**  Bunavail® (buprenorphine-naloxone buccal film),  Suboxone® (buprenorphine-naloxone sublingual film),  Zubsolv® (buprenorphine-naloxone sublingual tablets)

Dosing/Frequency: \_\_\_\_\_

**If the request is for reauthorization, proceed to reauthorization section**

Questions	Yes	No	Comments/Notes
1. Has the patient been diagnosed with opioid dependence?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member taking opioids other than requested in this authorization?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Will a urine drug screen and controlled substance database review be performed at least every 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a taper plan in place?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation (Detailed description required)</b>
5. Is the member enrolled in counseling and psychosocial support?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is buprenorphine without naloxone being requested? Please note that buprenorphine tablets without naloxone will only be considered in pregnancy or if there is a documented intolerance outside of the normal effects of naloxone.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Is Bunavail® being requested? Please note that Bunavail® will only be considered after a documented trial and failure of the generic sublingual tablets or Suboxone®.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Has the member used opioid dependence agents for 36 months or longer?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has a taper plan been implemented and followed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member's drug screen consistent with prescribed medications?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.</b>			
Additional information:			
Physician's Signature:			

**\*\*Failure to submit clinical documentation to support this request will result in delay and/or denial of the request\*\***

Policy PHARM- 050  
 Origination Date: 12/20/2017  
 Reviewed/Revised Date: 01/22/2020  
 Next Review Date: 01/23/2021  
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