UnitedHealthcare Community Plan

Suboxone/Subutex
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 contains 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:	Policy #:	Group #:

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 - Physician 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:**

Dispense as Written: □ Yes □ No

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

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information about this case, if any:

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

Please note:

- The preferred doses and formulation of Suboxone are the 2/0.5mg and 8/2mg films.

- For New Mexico members, the preferred doses and formulation of Suboxone are the 2/0.5mg, 4/1mg, and 12/3mg films, and Suboxone 8/2mg film or generic tablet.

All Requests:

- Does the patient have a DSM-V-TR diagnosis of opioid use disorder? □ Yes □ No

- Does the prescriber have an 'X' waivered DEA license to prescribe buprenorphine products, as per the requirements of the Drug Addiction Treatment Act of 2000 as per the SAMHSA website (http://www.samhsa.gov/)? □ Yes □ No

- Is the patient currently receiving substance abuse rehabilitation services as part of their therapy for opioid dependence? □ Yes □ No

- Is this request prescribed by or in consultation with an addiction psychiatrist or addictionologist? □Yes □ No

Requests for Subutex Requests ONLY:

- Does the patient have a documented intolerance to naloxone, or is the patient pregnant/breast feeding? □Yes □No
If yes, list details: _____

_____

Requests for Non-Preferred products: (please refer to www.uhccommunityplan.com)

- Is there a reason or special circumstance why the patient cannot use a preferred product? □Yes □No
If yes, list reason: _____

_____

_____

Requests for Continuation of Therapy:

- Has the patient been prescribed a buprenorphine product for the purpose of opioid use disorder maintenance therapy? □ Yes □ No

- Will the patient continue to receive urine drug screenings as part of treatment? □ Yes □ No

- Has the patient relapsed and will continue treatment for opioid dependence? □ Yes □ No
If yes, provide documentation regarding the details of the relapse: _____

_____

- Does the patient continue to receive substance abuse rehabilitation services as part of their therapy for opioid dependence? □ Yes □ No

Requests for Quantity Limit:

Note: Preferred medications have quantity limit of 90 films/tablets per month for initial fills.
Continuation of therapy fills have a quantity limit of 60 films/tablets per month.

- Is there a reason why a greater quantity of medication is required to treat the patient's condition? □ Yes □ No
If yes, list reason: _____

_____

Physician Signature: _____ **Date:** _____