

# Pharmacy

## PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

# Suboxone<sup>®</sup> (buprenorphine/naloxone)

**URGENT** (life threatening)

**Non-Urgent** (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

### Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

### Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

### PRODUCT INFORMATION

- Suboxone 2 mg/0.5 mg Film     **Dose/day:** \_\_\_\_\_
- Suboxone 8 mg/2 mg Film
- Suboxone 2mg/0.5mg or 8 mg/2 mg SL tabs (note: trial of Film is required)

### PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Suboxone<sup>®</sup> (buprenorphine/naloxone) requires the following information to certify:

#### Patient must have met the following requirements:

- Diagnosis of opioid dependence
- Suboxone will be prescribed by a DATA 2000 certified prescriber
- Patient will remain Abstinent of other opioid medications
- Suboxone is subject to a maximum covered dose of 24 mg/day
- Prescriber agrees to remain in compliance with REMS program

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**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION**

Authorization for Suboxone<sup>®</sup> (buprenorphine/naloxone) requires the following information to certify:

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**A. What is the patient's diagnosis?**

- Opioid Dependence  
 Other – *Rationale for use:* \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

**B. Is the prescriber DATA 2000 certified?**

- Yes  
 No– *Rationale for use:* \_\_\_\_\_

**C. Will the patient be prescribed or use other opioid medications while taking Suboxone?**

- No  
 Yes– *Rationale for use:* \_\_\_\_\_

**D. Will the prescribed Suboxone dose be equal to or less than 24 mg/day?**

- Yes  
 No– *Rationale:* \_\_\_\_\_

**\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\***  
**Please fax this request to: (877)974-4411 toll free or (616)942-8206**  
**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**