carolina complete health

Opioid Dependence Therapy Agents PA Request Form

Use this form to request coverage for Bunavail, buprenorphine/naloxone tablets, Zubsolv, and buprenorphine tablets

Suboxone Film and Sublocade do not require Prior Approval

Beneficiary Information

1. Beneficiary Last Name:_____2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Recipient Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____6a. Requester Contact Information. Name:_____Phone #:_____

Please answer 7a, 7b and 7c for all PA requests

7a. Does the beneficiary have a diagnosis of Opioid Dependence? Yes__No__

7b. What is the total daily dose of the opioid dependence therapy agent being requested?_____mg/day

7c. Has the Provider reviewed the Controlled Substances Reporting System Database prior to writing the prescription to ensure that concomitant opioid or use is not occurring? Yes__No____

Bunavail, Zubsolv, buprenorphine/naloxone tablets (questions 8-10)

8. Name of Medication requested:_____8a. Strength:_____8b. Quantity per 30 days _____

8c. Requested Duration _____

9. Has the beneficiary tried and failed on Suboxone Film? Yes_____No_____

10. If the beneficiary has not tried and failed on Suboxone Film, please describe the clinical reason the beneficiary cannot use Suboxone Film.

_____

_____

_____

_____

buprenorphine tablets (questions 11-16a)

11. Strength:_____11a. Quantity per 30 days_____11b. Requested Duration _____

12. Is the beneficiary unable to take Suboxone Film? Yes_____No_____

13. Is the beneficiary pregnant? Yes___ No_____13a. Is documentation attached? Yes_____No_____

14. If the beneficiary is pregnant, what is the estimated due date?_____**(approvals can be granted for up to 9 months)**

15. Is the beneficiary nursing? Yes___No_____**(approvals can be granted in 2 month intervals)**

16. Does the beneficiary have an allergy to naloxone with rashes, hives, pruritus, bronchospasm, angioneurotic edema, or anaphylactic shock? Yes_____No_____16a. Is documentation attached? Yes_____No_____

Signature of Prescriber:_____Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309