

Patient Name			
Patient DOB		Patient ID Number	
Physician Name		Specialty	
Phone	Fax	Suboxone DEA #	
Physician Address			
City		State	Zip
Drug Requested: <input type="checkbox"/> Suboxone [®] <input type="checkbox"/> Subutex [®]			
Directions: <input type="checkbox"/> 2mg <input type="checkbox"/> 8mg ___ tablets ___ time(s) per day			
Anticipated Length of Therapy:			
<input type="checkbox"/> Days		3 Months	
Diagnosis:			
<input type="checkbox"/> Initial Request		<input type="checkbox"/> Renewal Request	
<p>If the criteria below are met, then an initial maximum of 3 months of Suboxone[®] (1 month dispensed at a time), or up to a total of 4 weeks of Subutex[®], will be authorized, depending upon the request of the physician. If the criteria are not met, physician review will be necessary to determine whether other factors, such as age, co-morbidities, social situation, or prior treatment considerations, would support medical necessity for the initiation or re-initiation of Suboxone[®].</p> <p>➤ Please check all applicable criteria (explain unchecked boxes on 2nd page)</p>		<p>If the criteria below are met, then an additional 3-months of Suboxone[®] will be authorized (1 month dispensed at a time). If the criteria are not met, physician review will be necessary to determine whether other factors would support medical necessity for continuation of Suboxone[®].</p> <p>➤ Please check all applicable criteria (explain unchecked boxes on 2nd page)</p>	
<input type="checkbox"/> Patient age ≥16 years old; <input type="checkbox"/> Physician meets all qualifications to prescribe Suboxone [®] (Federal, State, and Local); <input type="checkbox"/> Patient is diagnosed with opiod dependence and/or opiod addiction <input type="checkbox"/> The risks of using Suboxone [®] with alcohol or benzodiazepines have been explained to the patient; <input type="checkbox"/> There are no untreated or unstable psychiatric conditions that would interfere with Suboxone [®] compliance; <input type="checkbox"/> Patient has had no more than one (1) prior attempt to treat opiate addiction with Suboxone [®] within the past 12 months; <input type="checkbox"/> Negative pregnancy test (for women, as indicated). If + test, explain choice of Suboxone [®] over alternatives on 2 nd page or with submitted OB office documents; <input type="checkbox"/> Documentation of referral to or active involvement in formal counseling with a licensed behavioral health provider – Where/who? _____ _____		<input type="checkbox"/> Consistent use of Suboxone [®] during the prior 3 months (this will be verified with pharmacy data; if inconsistent use is noted upon database search, then written explanation as to why Suboxone [®] should be continued despite apparent noncompliance would be needed); <input type="checkbox"/> Documentation of regular urine tests* that are negative for opiates since previous authorization; Dates? _____; <input type="checkbox"/> Documentation of consistent participation in formal counseling with a licensed behavioral health provider since previous authorization – When? _____ <input type="checkbox"/> Formal D&A Counseling Program is completed & patient is in “aftercare” (must be >12mos on Suboxone and be able to attest to and provide information on bottom of page 2). <input type="checkbox"/> Documentation of ongoing behavioral health care for co-existing behavioral health disorders.	

