

**SUBOXONE (buprenorphine/naloxone)
 Prior Authorization Request Form (Dosages > 24/6 mg)**

Phone: 1-866-287-6156 | Fax: 1-866-839-2372 | www.carefirstchpdc.com
 Monday – Friday: 8:00 AM to 4:30 PM

Coverage Policy: Coverage for the treatment of opioid dependence will be provided when ALL of the following conditions are met:

- Diagnosis of opioid dependence **AND**
- Verification from prescriber that he/she meets all of the qualification criteria to prescribe Suboxone **AND**
- Active participation of enrollee in a formal substance abuse counseling or treatment program; OR verification that prescriber (if a psychiatrist or certified addiction specialist) personally renders treatment or counseling services **AND**
- Documentation of a minimum of two performed toxicology screenings annually to evaluate and monitor any ongoing substance use for enrollee receiving treatment

****All fields must be complete and legible for review**
 Prior authorizations cannot be completed over the phone.**

Enrollee Information		Provider Information			
Enrollee Name:		Provider Name:			
Enrollee ID#:	Date of Birth:	NPI:	Specialty:		
Phone:		Phone:	Fax:		
Address:		Facility/Clinic Name: Address:			
Drug Allergies:		Pharmacy Name:	Pharmacy Phone: Pharmacy Fax:		
General Information					
Requested Drug:	Strength/ Formulation:	<input type="checkbox"/> Sublingual film <input type="checkbox"/> Sublingual tablet <input type="checkbox"/> Buccal film	Quantity:	Day Supply:	Dosing Frequency:
<input type="checkbox"/> Buprenorphine/naloxone <input type="checkbox"/> Suboxone (Brand)	_____ mg				
The following criteria must be met for the request to be considered complete <i>(Please check boxes)</i> :					
<input type="checkbox"/> Prescription Drug Monitoring Program (PDMP) reviewed		<input type="checkbox"/> Naloxone nasal spray prescribed/provided			
Clinical Information					
ICD-10 Codes(s):		Is enrollee currently pregnant? [For females, ages 16-45] <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(If yes, please complete pregnancy section on last page)</i>			
Diagnosis:		Is enrollee currently taking other sedating medications? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(e.g. benzodiazepines, sedatives/hypnotics, muscle relaxants, other opioids)</i>			
		Medication: _____		Diagnosis / ICD-10 code: _____	



This program is funded in part by the Government
 of the District of Columbia Department of Health Care Finance

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Initial Requests (Approval for 12 months)

<p>Please check all applicable criteria:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Enrollee is \geq 16 years old <input type="checkbox"/> There are no untreated/unstable psychiatric conditions that would interfere with Suboxone® adherence <input type="checkbox"/> Risks of using Suboxone with alcohol or benzodiazepines has been discussed with enrollee <input type="checkbox"/> Enrollee has been referred to or is currently participating in formal counseling or psychosocial treatment with a licensed behavioral health provider 	<p>Mental Health Substance Abuse Counseling:</p> <p>Counselor Name: _____</p> <p>Facility Name: _____</p> <p><i>(Please contact CareFirst CHPDC's behavioral health department at 202-821-1100 for assistance with finding a provider in network)</i></p>
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Renewal Requests (Approval for 12 months)

<p>Please check all applicable criteria:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Consistent use of Suboxone® since previous authorization <i>(will be verified via claims data)</i> <input type="checkbox"/> Ongoing behavioral health care for co-existing behavioral health disorders <i>(if applicable)</i> <input type="checkbox"/> Enrollee is currently participating in formal counseling or psychosocial treatment with a licensed behavioral health provider and adherent with sessions 	<p>Mental Health Substance Abuse Counseling:</p> <p>Counselor Name: _____</p> <p>Facility Name: _____</p>
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Additional Information

Please provide any additional pertinent information to support the requested use of Suboxone above the FDA-approved dosing limit.

Completed By: _____

Date: _____



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Pregnant Enrollees <i>(Only complete for pregnant or nursing women)</i>	
Is the member pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the member nursing?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant women?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant or nursing women?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Physician Signature: _____

Date Signed: _____



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