BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

SUBOXONE® / SUBUTEX® PRIOR AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

GENERAL INFORMATION *Request Type (please check one)*

Patient Name

Patient's Home Address

City | State | Zip

Date of Birth (mm/dd/yyyy)

Contract Number (include prefix)

PHYSICIAN INFORMATION

Physician Name

Practice Address

City | State | Zip

Office Phone | Office Fax

Practice Type
☐ PCP ☐ Specialty: _____

Physician NPI

Provider Number

SECTION I: TREATMENT INFORMATION (Please complete for all requests.)

☐ Suboxone ® ☐ Subutex ® Dose: _____ Directions: _____ Total Quantity: _____

Diagnosis/ICD-9 Code: _____ Data 2000 Waiver ID ("X" DEA number): _____

Supportive documentation is required for review. Attach medical records demonstrating the clinical evaluation, recovery treatment plan, documentation of enrollment in formal counseling program, and an attestation that the patient is abstinent from illicit drug use (including problematic alcohol and/or benzodiazepine use).

SECTION II: (Please complete for Subutex® requests only.)

Is the member pregnant? ☐ Yes ☐ No If yes, anticipated date of delivery: _____

Does the member have a documented allergic reaction or intolerance to naloxone? ☐ Yes ☐ No If yes, provide medical records documenting the reaction.

If you answered "No" to the two questions above, what is the medical necessity for prescribing Subutex®, rather than Suboxone®, for this member?

_____

_____

SECTION III: (Please complete for authorization renewal requests only.)

Please check all applicable criteria and **attach supportive documentation** as to why continuation of therapy is necessary.

☐ Consistent use of Suboxone® since previous authorization (if inconsistent use is noted in pharmacy database, then written explanation as to why Suboxone® should be continued despite apparent noncompliance would be needed).

☐ Documentation of monthly urine tests that are negative for opiates since previous authorization

☐ Documentation of consistent participation in formal counseling since previous authorization? _____
Anticipated discontinuation date: _____

I certify this information is complete and correct to the best of my knowledge.

_____ _____
Physician Signature Date

SUBMISSION INSTRUCTIONS

(Please attach any additional medical justification)

FAX You may fax the signed and completed form to **Pharmacy Review** at:
866 606-6021

MAIL *You may mail the signed and completed form to:*
Pharmacy Review
Post Office Box 3210
Auburn, AL 36831