



GENERAL INFORMATION *Request Type (please check one)*

Patient Name			Date of Birth (mm/dd/yyyy)													
Patient's Home Address			<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>													
City	State	Zip	Contract Number (include prefix)													
			<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>													

PHYSICIAN INFORMATION

Physician Name			Practice Type <input type="checkbox"/> PCP <input type="checkbox"/> Specialty: _____													
Practice Address			Physician NPI													
City	State	Zip	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>													
Office Phone	Office Fax		Provider Number													
			<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>													

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 and recovery treatment plan.

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