## **Prior Authorization Form Buprenorphine Products for Opiate Addiction** Fax this form to: 1-800-424-3260 A fax cover sheet is not required. **Instructions:** Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Information contained in this form is Protected Health Information under HIPAA. **NON-URGENT EXIGENT CIRCUMSTANCES** MEMBER INFORMATION Member's Last Name: Member's First Name: Member's Identification Number: Date of Birth: **Member's Address:** ZIP: City: State: PRESCRIBER INFORMATION Prescriber's Last Name: **Prescriber's First Name:** National Provider Identifier (NPI) Number: **DEA Number: Office Phone Number:** Office Fax Number: **REQUESTED MEDICATION** Buprenorphine (generic Subutex<sup>®</sup>) Subutex<sup>®</sup> Bunavail<sup>®</sup> buccal film Bupenorphine/Naloxone (generic Suboxone<sup>®</sup>) Suboxone® film Suboxone® tab Zubsolv® Strength: Directions: Quantity: (Form continued on next page.) © 2017–2021, Magellan Health, Inc. All rights reserved. MHID: MRXCOM02 01

Magellan Rx Management – Commercial Clients

## Prior Authorization Form: Buprenorphine Products for Opiate Addiction

Me	Member's Last Name:							ſ	Member's First Name:													
											_ L											
CLI	NICA	L CR	ITERI	1																		
1.	What	is th	ne mer	nber	's prir	nary	diag	gnosi	is?													
า	What is the XDEA number?										-											
Ζ.	vviidt	is ti		Anu	mber	ŗ																
3.	Indicate the request type																					
	N	New Start Renewal Date therapy was started																				
4.	Does	the	memb	er ha	ve a d	comp	oreh	ensiv	ve tre	eatm	ent	plan	on fil	e wit	h the	e men	nber?					
	Ye		N																			
5.		Is the member actively involved in substance abuse counseling or was the member provided a referral?																				
	∐ Ye		N 🛄				:		امم ما				~.									
	II <b>NO</b> ,	If <b>No</b> , provide reason member is not attending counseling:																				
6.	Has tl	he pi	rescrib	er ch	ecke	d the	stat	te op	bioid	data	base	e to o	ensur	e the	men	nberi	is not	preso	ribe	d con	curre	ent
	Has the prescriber checked the state opioid database to ensure the member is not prescribed concurrent opioid medications?																					
	Yes No																					
	If <b>No</b> , provide details:																					
7.	Does	Does the member have a Probuphine <sup>®</sup> (buprenorphine) implant?																				
	⊡ Y€		<b>N</b>				•				•											
For	r Fema	le N	lembe	rs Or	ıly:																	
1.	Does	the i	memb	er ha	ve a r	negat	tive	preg	nanc	y tes	st wi	ithin	30 da	ys of	this	requ	est?					
	Yes No																					
	If <b>No</b> , provide details:																					
For		e Ing	redier	nt Ru	nrenc	ornhi	ne (	)nlv														
	Is the	-			-	-		-		enor	bin	e du	ring p	regna	ancví	?						
	Υe		N	-	0	0							01	-0								
2.	Is this	s req	uest fo	or a 2	-day i	induc	ctior	n to S	Subo	xone	® th	erap	y?									
	Ye	es	N	0																		
3.	Does				ve an	allei	rgy t	o na	loxo	ne?												
	Ye		N																			
	lf <b>No</b> ,	prov	vide de	etails	•																	

(Form continued on next page.)

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Member's Last Name:											N	Member's First Name:											
CL	INICAL	. CRI	FERIA	( <i>co</i>	NTII	NUEL	D)																
Fo	r Rene	wals	Must	also	com	plet	e the	e sec	tions	s abo	ove.):												
1.	Has th Ye If <b>No</b> ,	S	No	C		nplia	nt w	vith r	no ga	ps in	ther	apy s	ince i	nitial	auth	noriza	ation	!?					
2.	Has th Ye If <b>No</b> ,	S	No	D		d att	endi	ing s	ubsta	ance	abus	e cou	inselii	ng?									
3.	Has th which Ye If <b>No</b> ,	is po s	sitive	for b	upre			-	-		-			one	with	in 60	) day	s prio	or to 1	this r	reque	est	
4.	What date was the last urine drug screen performed?																						
 Pre	escribe	r Sigr	ature	Red	quire	d)										-	Date						
(By	/ signa	ture, i	the Ph	ysici	an co	onfirr	ns tl	he al	bove	infoi	rmati	on is	accur	ate a	nd v	erific	able k	ру ра	tient	reco	rds.)		
Fax	x this f	orm t	o: 1-8	00-4	24-3	260																	
Ma c/c	<b>ail requ</b> agellan o Mage 01 E. W	Rx M llan F	anage Iealth	, Inc.		or Aı	utho	rizat	ion P	Progr	am												

Phoenix, AZ 85034 Phone: 1-800-424-3312