Oral Buprenorphine Products Prior Authorization Request Form (Page 1 of 2) DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)				
Member Name:			Provider Name:				
Insurance ID#:			NPI#: Specialty:				
Date of Birth:			Office Phone:				
Street Address:			Office Fax:				
City:	State:	Zip:	Office Street Address:				
Phone:		City:	State: Zip:				
Medication Information (required)							
Medication Name:			Strength:	quirou)	Dosage Form:		
☐ Check if generic substitution is acceptable			Directions for Use:				
☐ Check if request is for continuation of therapy							
Clinical Information (required)							
Select the diagnosis below:							
☐ Opioid use disorder							
Other diagnosis:				ICD-10 Code(s):			
Quantity Limit and Day Supply Limit Requests:							
What is the quantity requested per DAY?							
Is the requested medication being used concurrently with comprehensive addiction care (this includes participation in nonpharmacological interventions such as drug abuse counseling, self-help programs, behavioral therapy, or other psychosocial services)? Yes No							
Is there documentation that a urine toxicology screen has been conducted? Yes No							
Does the requested dose and frequency exceed FDA approved dosing? ☐ Yes ☐ No							
Is the requested dose and frequency supported by compendia? ☐ Yes ☐ No							
Can the requested dose be achieved with commercially available dosage forms? Yes No							
Has the patient had an inadequate response to lower doses? ☐ Yes ☐ No							
For opioid regimens containing greater than 90 morphine milligram equivalents per day, answer the following:							
Does the patient have pain associated with active cancer treatment, cancer not in remission, or sickle cell anemia? □ Yes □ No							
Does the patient have severe, persistent chronic non-cancer pain? Yes No							
If yes , document the diagnosis associated with the pain:							
Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)? □ Yes □ No							
Was the requested medication regimen prescribed by or in consultation with a pain management specialist within the last 6 months? ☐ Yes ☐ No							
If yes , provide the r	and date of last visi	t. Name:		Date:			
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Select if the pain management specialist is board certified by one of the following below:
☐ American Board of Anesthesiology - Pain Management
☐ American Board of Psychiatry & Neurology - Pain Management
☐ American Board of Physical Medicine & Rehabilitation
☐ American Osteopathic Association - Pain Management
Select if the prescriber has evaluated the patient for the following therapies below: Physical therapy
□ Psychotherapy
Adjuvant medications specific to causative condition including but not limited to any of the following: Antidepressants, anticonvulsants, muscle relaxants, anti-inflammatory agents
Reauthorization
If this is a reauthorization request, answer the following:
Does the patient have pain associated with active cancer treatment, cancer not in remission, or sickle cell anemia? □ Yes □ No
Does the patient have severe, persistent chronic non-cancer pain? Yes No
If yes , document the diagnosis associated with the pain:
Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)? □ Yes □ No
Is there documentation that a urine drug screen (UDS) will be performed by the prescriber within 1 year of request? ☐ Yes ☐ No
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?
<u>Please note</u> : This request may be denied unless all required information is received.