Prior Authorization Form

Suboxone

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Suboxone.

Drug Name (select from list of drugs shown)

Buprenorphine-Naloxone 2mg-0.5mg SL Tablets	Buprenorphine-Naloxone 8mg-2mg SL Tablets	Suboxone Film 12-3mg (buprenorphine-naloxone)
Suboxone Film 2-0.5mg (buprenorphine-naloxone)	Suboxone Film 4-1mg (buprenorphine-naloxone)	Suboxone Film 8-2mg (buprenorphine-naloxone)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the drug being prescribed for the treatment of opioid dependence?	Y N
2.	Is the drug being used as part of a complete program for the treatment of opioid dependence including ALL of the following?	Y N

Behavioral therapies (e.g., individual therapy, group counseling, family behavior therapy, cognitive behavioral therapy, motivational enhancement, motivational

	incentives) \ Initial assessment including physical exam with HIV and hepatitis C screening / Diversion control protocols such as observed dosing, pill counts, random drug tests \ Drug of abuse testing including buprenorphine's metabolite (norbuprenorphine) and heroin \ Use of the Prescription Drug Monitoring Program (PDMP) if available in state.
3.	Does the prescriber agree not to prescribe other opioids AND does the patient agree not to take other opioids while the patient is taking the requested drug? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date