

HEALTH PARTNERS MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Suboxone® - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this member that may support approval. Please answer the following questions and sign.				
Q1. What is the duration of the therapy requested?				
\Box 1 month or less		□ More than 1 month		
Q2. Is the request for filr	n strips?			
□ Yes	🗆 No			
Q3. What is the age of the patient?				
\Box Less than 16 years		\Box 16 years or greater		
Q4. If the patient is female, is she negative for pregnancy?				
🗆 Yes	□ No	□ Male		
Q5. Is the physician certified to prescribe Suboxone® / Subutex® for office-based treatment of opioid dependence (is in accordance with DATA 2000, previously notified the Substance Abuse and Mental Health Services Administration (SAMHSA) of their intent to treat patients with Suboxone® / Subutex® and was issued a special DEA number)?				
Q6. Has the patient been formally diagnosed with opioid dependence according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)?				
Q7. Is there documentation of referral to or participation in a substance abuse or behavioral heatth (BH) treatment program, BH counseling, or an addictions recovery program? During the intial course of treatment, referral and enrollment must be with a licensed Drug and Alcohol (D&A) or BH provider. Documentation must be attached.				
Q8. Is the name, location and counseling schedule attached? Must attached.				
	□ No			
Q9. Is there a patient treatment contract in place? Must attach a patient signed copy of contract.				

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Patient Name:		Prescriber Name:	
🗆 Yes 🗆 N	lo		
Q10. Does the patient treatment contract include consequences of violating the rules of the contract?			
🗆 Yes 🛛 🗆 N	lo		
Q11. Does the patient have an opioid-positive drug screen?			
🗆 Yes 🛛 🗆 N	10		
Q12. Is the dose being prescribed greater than 24 mg/day?			
🗆 Yes 🛛 🗆 N	lo		
Q13. Is the patient concurrently taking opiods and/or benzodiazepines while on Suboxone?			
🗆 Yes 🛛 🗆 N	lo		
Q14. Comments:			

Prescriber Signature

Date