

Buprenorphine and Buprenorphine/Naloxone Prior Authorization Request Form

For assistance, please call 1-800-988-4861 or fax completed form to 570-271-5610.

Medical documentation may be requested. This form will be returned if not completed in full.

Patient Information				Prescriber Information			
Patient Name:			Prescriber Name:				
Member ID#:			NPI# (if available):				
Address:		Address:					
City:		State:	City: Sta		State:		
Home Phone:		Zip:	Offic	Office Phone #: Office Fax #:		Zip:	
Sex (circle): M F DOB:			Contact Person:				
	D	iagnosis and Me	dical I	nformation			
Medication:		Strength and Route of Administration:		Frequency:			
D New Prescription OR Date Therapy Initiated:		Expected Length of Therapy:Qty:		Qty:			
Height/Weight:	Drug Allerg	gies: Diagnosis.					
Prescriber's Signature:						Date:	
Criteria for Prior Authorization FORM CANNOT BE PROCESSED UNLESS ALL BELOW ARE COMPLETE							
If buprenorphine is requested, list the medical reason that buprenorphine/naloxone can't be used:							
 If Zubslov is requested, list the medical reason that generic buprenorphine/naloxone tabs and Suboxone film cannot be used: 							
 Results of most recent lab screen, drugs present: D Buprenorphine D Other opiates D Other controlled substances (list below) Screen Date (Must be within 28 days of Prior Authorization							
Request):							

•	 Patient has been adherent to buprenorphine or buprenorphine/naloxone therapy:						
lf "l	lo" how is this being address	ed?					
•		y > 1 year and total daily bupre) please provide rationale for do	norphine dose is > 8 mg/day (or ose:				
•	behavioral health provider	and is actively involved in forma counselor and/or facility:	al counseling with a licensed				
If "No" rationale for non-participation:							
For	Health Plan internal use only	<i>:</i>					
Ľ	Date received	Date reviewed	Request approved: Y/N/NA				

Instructions for Completing the Form

- 1. Submit a separate form for each medication.
- 2. Complete **ALL** information on the form. *NOTE:* The prescribing physician should, in most cases, complete the form.
- 3. Please be sure to provide the physician address in a legible format, as it is required for notification.
- 4. Once form is completed, mail or fax to:

Geisinger Health Plan Attn: Pharmacy Department 32-45 100 N. Academy Avenue Danville, PA 17822 Fax: 570-271-5610