

## Buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®, Zubsolv®) Prior Authorization Request Form

**IF REQUEST IS MEDICALLY URGENT,**  
**PLEASE CALL 1-800-988-4861 or fax to 570-271-5610, MONDAY-FRIDAY 8am-5pm**

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:		State:	
Home Phone:		Zip:		Office Phone #:		Office Fax #:	
Sex (circle):    M    F		DOB:		Contact Person:			
Diagnosis and Medical Information							
Medication:			Strength and Route of Administration:			Frequency:	
<input type="checkbox"/> New Prescription    OR Date Therapy Initiated:			Expected Length of Therapy:			Qty:	
Height/Weight:		Drug Allergies:			Diagnosis:		
Prescriber's Signature:							Date:
Criteria for Prior Authorization							
FORM CANNOT BE PROCESSED UNLESS ALL BELOW ARE COMPLETE							
<ul style="list-style-type: none"> <li>If buprenorphine is being requested medical reason that buprenorphine/naloxone can't be used; if Zubsolv® is being requested medical reason that formulary alternatives can't be used: _____</li> <li>Date and results of most recent lab screen (<b>must be within 28 days of PA request</b>), Screen Date: _____                Drugs present:   <input type="checkbox"/> Buprenorphine    <input type="checkbox"/> Other opiates    <input type="checkbox"/> Other controlled substances (list below)                If buprenorphine not present and opiates or other controlled substances present how is this being addressed?                _____                _____</li> <li>Patient has been adherent to buprenorphine or buprenorphine/naloxone therapy:    <input type="checkbox"/> Yes    <input type="checkbox"/> No                If "No" how is this being addressed? _____                _____</li> <li>If patient has been on therapy &gt; 1 year and total daily buprenorphine dose is &gt; 8 mg/day (or 11.4 mg/day for Zubsolv®) please provide rationale for dose:                _____                _____</li> <li>Patient has been referred to and is actively involved in formal counseling with a licensed behavioral health provider  <input type="checkbox"/> Yes    <input type="checkbox"/> No    Name of counselor and/or facility: _____                If "No" rationale for non-participation: _____                _____</li> </ul>							
Request for Expedited Review							
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW [24 HOURS] → BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING FOR THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION							
<i>For Health Plan internal use only:</i> 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 30-45  
100 N. Academy Avenue  
Danville, PA 17822  
Fax: 570-271-5610

### **Buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®, Zubsolv®) Prior Authorization Clinical Management Procedures\***

The Health Plan's<sup>1</sup> Pharmacy Department maintains a process by which Health Care Providers can:

- Request precertification for Buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®, Zubsolv®)

Buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®, Zubsolv®) requests will be evaluated and a determination of coverage made utilizing all the following criteria:

1. Member's eligibility to receive requested services (enrollment in the plan, prescription drug coverage, specific exclusions in Member's contract)
2. Specific criteria listed on the form

Please note that initial authorization will be for 3 months and subsequent authorizations will be for 12 months.

A Quantity Limit of a 34-day supply per fill will apply.

\* Please refer to the Health Plan's Provider Guide and Formularies for further information.

***Please note that the Prior Authorization process is an independent process and is not in conjunction with the Specialty Pharmacy Drug Program.***

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<sup>1</sup> Geisinger Health Plan and Geisinger Indemnity Insurance Company shall be collectively referred to as "Health Plan."