

# District of Columbia Pharmacy Program Initial Request Prior Authorization Form

## Buprenorphine/Naloxone and Subutex® (Buprenorphine)

REQUEST DATE:           /           /

## PATIENT INFORMATION

PATIENT'S MEDICAID ID NUMBER

[illegible]

PATIENT'S DATE OF BIRTH

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| PATIENT'S FULL NAME |  |
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[illegible]

## PATIENT INFORMATION

**PRESCRIBER'S FULL NAME**

[illegible]**PRESCRIBER PHONE NUMBER:**













**PRESCRIBER FAX NUMBER:**

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**PRESCRIBER NPI #:**

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PERSON COMPLETING FORM

**DRUG REQUESTED: (USE ONE FORM PER DRUG)**

[illegible]

**BUPRENORPHINE/NALOXONE AND SUBUTEX® STRENGTH AND DOSAGE FORM**

|                   |                                         |                                                                     |                                         |                                                                     |                                        |                                        |
|-------------------|-----------------------------------------|---------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------------|----------------------------------------|----------------------------------------|
| <b>Suboxone®:</b> | <b>2 mg:</b>                            | <input type="checkbox"/> SL Film or <input type="checkbox"/> Tablet | <b>8 mg:</b>                            | <input type="checkbox"/> SL Film or <input type="checkbox"/> Tablet | <input type="checkbox"/> 4 mg SL Film  | <input type="checkbox"/> 12 mg SL Film |
| <b>Zubsolv®:</b>  | <input type="checkbox"/> 1.4mg Tablet   | <input type="checkbox"/> 2.9mg Tablet                               | <input type="checkbox"/> 5.7mg Tablet   | <input type="checkbox"/> 8.6mg Tablet                               | <input type="checkbox"/> 11.4mg Tablet |                                        |
| <b>Bunavail®:</b> | <input type="checkbox"/> 2.1 mg SL Film |                                                                     | <input type="checkbox"/> 4.2 mg SL Film | <input type="checkbox"/> 6.3 mg SL Film                             |                                        |                                        |
| <b>Subutex®:</b>  | <input type="checkbox"/> 2 mg Tablet    |                                                                     | <input type="checkbox"/> 4 mg Tablet    |                                                                     |                                        |                                        |

**Length of Therapy:** \_\_\_\_\_

**Diagnosis:**\_\_\_\_\_

**Directions:** \_\_\_\_\_

**Criteria for Use:** If the criteria below are met, then an initial authorization for a maximum of 12 months of Buprenorphine/Naloxone or Subutex® (Buprenorphine) (one month dispensed at a time) will be authorized depending upon the request of the physician's rational and/or additional information, which may be relevant to the review of this prior authorization request. If criteria listed below are not met, address those issues and explain why Buprenorphine/Naloxone or Subutex® (Buprenorphine) is still felt to be medically indicated:

**Please check all applicable criteria:**

- ☐ Patient age  $\geq$  16 years old.
- ☐ Physician meets all qualifications to prescribe Buprenorphine/Naloxone or Subutex® (Buprenorphine) (Federal, State, Local).
- ☐ Patient is diagnosed with opioid dependence and/or opioid addiction.
- ☐ The risks of using Buprenorphine/Naloxone or Subutex® (Buprenorphine) with alcohol or Benzodiazepines have been explained to the patient.
- ☐ There are no untreated or no unstable psychiatric conditions that would interfere with Buprenorphine/Naloxone or Subutex® (Buprenorphine) compliance.
- ☐ A negative pregnancy test (for women, as indicated). If positive test; explain choice of Buprenorphine/Naloxone over alternatives in additional information section.
- ☐ Documentation of referral to or active involvement in formal counseling with a licensed behavioral health provider.
- ☐ Patient is actively engaged in “after-care” programs, such as NA or AA, and attending weekly.

**Additional Information:**

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**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.