REALRx

PRIOR AUTHORIZATION REQUEST FORM

OPIOID DEPENDENCE AGENTS

buprenorphine, buprenorphine-naloxone, Bunavail®, Suboxone®, Zubsolv®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ buprenorphine-naloxone sublingual (generic) tablets, ☐ (generic) sublingual film

Non-preferred: ☐ Bunavail® (buprenorphine-naloxone buccal film), ☐ buprenorphine (generic) sublingual tablet, ☐ Suboxone® (buprenorphine-naloxone sublingual film), ☐ Zubsolv® (buprenorphine-naloxone sublingual tablets)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Has the member been diagnosed with opioid dependence?	☐	☐	
3. Is the member taking opioids other than requested in this authorization?	☐	☐	
4. Will a urine drug screen and controlled substance database review be performed at least every 3 months?	☐	☐	**Please provide documentation**
5. Does the treatment plan include a taper or discontinuation plan?	☐	☐	**Please provide documentation (Detailed description required)**
6. Is the member enrolled in counseling and psychosocial support?	☐	☐	**Please provide documentation**
7. Is buprenorphine without naloxone being requested? Please note that buprenorphine tablets without naloxone will only be considered in pregnancy or if there is a documented intolerance outside of the normal effects of naloxone.	☐	☐	**Please provide documentation**
8. Is Bunavail® being requested?	☐	☐	**Please provide documentation**

Please note that Bunavail® will only be considered after a documented trial and failure of the generic buprenorphine-naloxone sublingual tablets or film			
9. Has the member used opioid dependence agents for 36 months or longer?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	**Please provide documentation**
2. Has a taper plan been implemented and followed?	☐	☐	**Please provide documentation**
3. Is the member's drug screen consistent with prescribed medications?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

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Policy PHARM- 050
Origination Date: 12/20/2017
Reviewed/Revised Date: 07/31/2023
Next Review Date: 07/31/2024
Current Effective Date: 08/01/2023