ProCare Rx

Suboxone®/Subutex®

Ticket #: ____________ Request Date: ____________ Request Time: ____________

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Suboxone®/Subutex®. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:		Plan Name/Plan ID:
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

Complete this section for Initiation and Continuation: (Refer to page 2 for required documents and the prescriber's signature.)

Check one: ☐ Suboxone® ☐ Subutex® Dose: ____________ Directions: ____________

Check one: ☐ Induction ☐ Stabilization ☐ Maintenance <u>Induction Date</u>: (required) ____/____/____

Anticipated length of therapy: ____________

1. Is the patient pregnant or nursing? If pregnant, expected date of delivery: ____/____/____ YES NO
2. Is this request for the treatment of opioid dependence? YES NO
3. Is this request for the treatment of pain? YES NO
4. Is the patient taking other opioids, tramadol or carisoprodol? YES NO
5. Is the prescriber registered to prescribe Suboxone/Subutex under the Substance Abuse and Mental Health Services Administration (SAMHSA)? YES NO

Initiation of therapy or initial review: (Supporting documentation is required for answers to all the questions.)

1. Does the patient have a confirmed DSM-IV-TR diagnosis of opioid dependency? YES NO
2. Has an initial drug screen been performed to verify presence of opiates and other substances? YES NO
3. Has the patient failed more than one prior attempt with opiates agonist treatment within the past 12 months? YES NO
   If YES, provide date(s) of relapse(s): ____________
4. Does the patient have co-morbid conditions that would interfere with compliance? YES NO
   If YES, please list: ____________
5. What best describes the recovery environment for this patient? ☐ Supportive ☐ Unsupportive ☐ Toxic
6. Has the patient been referred to a support group or licensed mental health counselor for psychological counseling? YES NO
   If YES, specify: ____________

(continuation on page #2)

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.

Initiation of therapy or initial review: (Continued from page 1)

7. Has the patient been referred for a psychiatric evaluation if indicated? YES NO
8. Has the patient signed a contract (attach) and committed to both pharmacologic and non-pharmacologic modalities of treatment? YES NO

   Date of next visit? ______

Continuation of Therapy: (Supporting documentation is required for answers to all the questions.)

1. Is the patient compliant with pharmacologic therapy? YES NO

   Drug screen date: (please attach) ______
2. Is the patient compliant with non-pharmacologic therapy? YES NO

   Provide details (support type [group or individual], frequency of attendance, dates):

   ______ YES NO
3. How long has the patient been stable at the current dose? ______ YES NO
4. Is the patient ready to taper the dose at this time? YES NO

   If NO, provide rationale: ______

   If YES, provide taper schedule: ______
5. Is the revised individual treatment plan reflecting follow-up at the most current office visit attached for review? YES NO

   Date of next office visit: ______

Prior Authorization Standards for Review:

Prior authorization review is intended for office-based treatment of opioid dependency for individuals who meet the following criteria:

- With an adequate amount of psychosocial support; family/peers
- With a readiness for change and a personal commitment to live a drug-free lifestyle
- With a willingness to comply with all elements of the treatment plan, including pharmacologic and non-pharmacologic aspects of the established protocol
- With consistent regular drug screens that are negative for opiates
- With a willingness to abstain from illicit drugs

Helpful links:
SAMHSA recommendations: http://www.samhsa.gov
National Library of Medicine for Clinical Guidelines for Use of Buprenorphine in the Treatment of Opioid Addiction
http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A72248

Authorized Medical Signature:

Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

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