

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Zubsolv®** buprenorphine and naloxone. 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)			
1. Has documentation been provided to verify that the patient has met diagnostic criteria for opioid dependence? (Please provide documentation.)		YES	NO
2. Has a schedule been submitted that includes, but not limited to: return visits, assessment of progress, dosage evaluations, and psychosocial support? (Please provide documentation.)		YES	NO
3. Has the patient taken initial drug screen to verify presence of opiates and other substances? (Please provide documentation.)		YES	NO
4. Has the patient failed more than one prior attempt with opiates agonist treatment within the past 12 months?		YES	NO
5. Has the patient been referred to a support group or licensed health counselor for psychosocial counseling?		YES	NO
If YES, specify: _____			
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

**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.

Prior authorization forms are reviewed at least annually and are available at www.procarerx.com. Medical Review Criteria are reviewed at least annually. Revised 09/2015