



**PRIOR AUTHORIZATION REQUEST FORM**

**EOC ID:  
SUBOXONE®**

**Phone: 215-991-4300 Fax back to: 866-240-3712**

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

<b>Patient Name:</b>	<b>Physician Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

<b>Please answer the following questions and sign below:</b>
Q1. What is the age of the patient? Less than 16 years      16 years or greater
Q2. What is the duration of the therapy requested? 1 month or less      More than 1 month
Q3. Has the patient been formally diagnosed with opioid dependence according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)? Yes      No
Q4. Is the physician certified to prescribe Subutex® / Suboxone® for office-based treatment of opioid dependence (is in accordance with DATA 2000, previously notified the Substance Abuse and Mental Health Services Administration (SAMHSA) of their intent to treat patients with Subutex® / Suboxone®, and was issued a special DEA number)? Yes      No
Q5. Is there a Physician-patient agreement in place stating that patient will refrain from use of opioids while on Suboxone? Yes      No
Q6. Is the patient currently taking other opioids? Yes      No

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**