



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 note any information left blank or illegible may delay the review process.**

Patient Name: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone:	Prescriber Name: Fax: Phone: Office Contact: NPI: State Lic ID: Address: City, State, Zip:
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Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
Q1. What is the duration of the therapy requested? 1 month or less More than 1 month
Q2. Is the patient concurrently taking opioids, benzodiazepines, and/or skeletal muscle relaxants while on Suboxone? Yes No
Q3. Is the urine drug screen negative for opioids, benzodiazepines, skeletal muscle relaxants, and illicit drugs? Yes No
Q4. Does the patient have a positive drug screen that demonstrates compliance with Suboxone? Yes No
Q5. Has the patient participated in a substance abuse, BH counseling or treatment program, or an addictions recovery program? Documentation must be attached. Yes No
Q6. Comments:

Physician Signature

Date