



**PRIOR AUTHORIZATION REQUEST FORM**

**EOC ID:**

**Subutex® (buprenorphine)**

**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.**

**Patient Name:**

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

**Physician Name:**

Fax:

Phone:

Office Contact:

NPI:

State Lic. Id:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

**Please answer the following questions and sign below:**

Q1. What is the duration of the therapy requested?  
1 month or less      More than 1 month

Q2. Does the patient's prescription profile show concurrent use of other opioids?  
Yes      No

Q3. Has documentation showing monthly urine tests negative for opiates been provided?  
Yes      No

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

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