1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Bunavail® and buprenorphine-naloxone sublingual (SL) tablet
Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Treatment of opioid dependence
❑ Other diagnosis:_____ ICD-10 Code(s): _____

Clinical information:
Is the prescriber certified through Substance Abuse and Mental Health Services Administration (SAMHSA)? ❑ **Yes** ❑ **No**
If **yes**, please provide registration number**:** _____

Is the prescription part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training)? ❑ **Yes** ❑ **No**

Is the patient receiving any other opioids, written by the same or a different prescriber within the past 7 days? ❑ **Yes** ❑ **No**

Is the patient pregnant? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following:
Is the prescriber certified through SAMHSA? ❑ **Yes** ❑ **No**
If **yes**, please provide registration number**:** _____

Is the prescription part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training)? ❑ **Yes** ❑ **No**

Has the patient received any other opioids, written by the same or different prescriber since starting therapy? ❑ **Yes** ❑ **No**

Is the prescriber aware of and acknowledges that opioid history was necessary as part of good medical practices in the care of the patient? ❑ **Yes** ❑ **No**

Is the patient pregnant? ❑ **Yes** ❑ **No**

Are random urine drug screens being used by the prescriber to evaluate and assess the patient's progress (e.g., relapse, progress/accomplishment of treatment goals)? ❑ **Yes** ❑ **No**

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Bunavail® and buprenorphine-naloxone sublingual (SL) tablet
Prior Authorization Request Form (Page 2 of 2)

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	