AmeriHealth Caritas Louisiana

Suboxone®/Subutex® Pharmacy Prior Authorization Form

Confidential Information

Patient Name		Patient DOB
Patient AmeriHealth Caritas ID Number		Specialty
Physician Name		NPI#
Phone	Fax	Suboxone DEA#
Physician Address		
City	State	Zip Code
Drug Requested:	**Suboxone®**: ☐ 2/0.5mg ☐ 8/2mg ☐ Tablet **or** ☐ Film **Subutex®**: ☐ 2mg ☐ 8mg	
Directions:		
Anticipated Length of Therapy: _____Days _____Months (Max: 3 months for initial or 6 months for renewal request)		
Diagnosis and Code:		

☐ Initial Request	☐ Renewal Request
If the criteria below are met, Suboxone ® will be approved for a duration of 3 months, or up to a total of 4 weeks of Subutex ® will be authorized, depending upon the request of the physician. If the criteria are not met, physician review will be necessary to determine whether other factors, such as age, co-morbidities, social situation, or prior treatment considerations, would support medical necessity for the initiation or re-initiation of Suboxone®.	If the criteria below are met, Suboxone ® will be approved for a duration of 6 months. If the criteria are not met, physician review will be necessary to determine whether other factors would support medical necessity for continuation of Suboxone®.
➢ **Please check all applicable criteria** *(explain unchecked boxes on 2nd page)*	➢ **Please check all applicable criteria** *(explain unchecked boxes on 2nd page)*
☐ Patient age ≥ 16 years old; ☐ Physician meets all qualifications to prescribe Suboxone® (Federal, State, and Local); ☐ The risks of using Suboxone® with alcohol or benzodiazepines have been explained to the patient; ☐ There are no untreated or unstable psychiatric conditions that would interfere with Suboxone® compliance; ☐ Patient has had no more than one (1) prior attempt to treat opiate addiction with Suboxone®; ☐ Negative pregnancy test (for women, ages 16-45). If + test, explain choice of Suboxone® over alternatives on 2nd page or with submitted OB office documents; ☐ Documentation of referral to or active involvement in formal counseling with a licensed behavioral health provider – Name of counselor and/or facility: _____ _____ _____	☐ Consistent use of Suboxone® since previous authorization (this will be verified with pharmacy data; if inconsistent use is noted upon database search, then written explanation as to why Suboxone® should be continued despite apparent noncompliance would be needed); ☐ Documentation of regular (every 1 to 2 months) urine tests* that are negative for opiates since previous authorization: Please provide dates: _____ _____ ☐ Documentation of consistent participation in formal counseling with a licensed behavioral health provider since previous authorization – Name of counselor and/or facility: _____ How often:_____ ☐ Formal D&A Counseling Program is completed & patient is in "aftercare" (must be > 12mos on Suboxone and be able to attest to and provide information on bottom of page 2). ☐ Documentation of ongoing behavioral health care for co-existing behavioral health disorders.

CONTINUED ON THE NEXT PAGE

Rationale and/or additional information, which may be relevant to the review of this prior authorization request (if criteria listed above are not met, address those issues and explain why Suboxone® is still felt to be medically indicated):

☐ *Patient has consistently been on Suboxone® for extended period of time (how long? _____), has been consistently off opiates (how long? _____), and has successfully completed all prescribed formal counseling D&A programs.*

AND

☐ *Patient is actively engaged in "after-care" programs, such as NA or AA, attending every _____ weeks.*

☐ ***The patient has agreed that information about his/her treatment with Suboxone can be shared between his/her PH and BH MCO's, and with his/her Primary Care and Behavioral Providers, in order to better coordinate the services needed to successfully treat his/her substance abuse condition. I attest that a copy of the necessary specific written consent is filed in the patient's medical record.***

Physician Signature	Date

Please return this form to:
PerformRx
AmeriHealth Caritas Louisiana
200 Stevens Drive
Philadelphia, PA 19113

Or FAX to: **855-452-9131**

**Note: Do not send any actual drug screening lab result documents with this form. The information you check off and the dates entered, along with your signature on this form, will be acceptable.*

Revised 11/2012

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