Oral Buprenorphine & Buprenorphine/Naloxone Products

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	

Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:

Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.

Preferred Products	Daily Dose Limit	Daily Quantity Limit*
buprenorphine tablet	24mg	3 sublingual tabs
buprenorphine/naloxone tablet	24mg	3 sublingual tabs
Suboxone film	24mg	3 sublingual films
Non-Preferred Products	**Daily Dose Limit**	**Daily Quantity Limit**
buprenorphine/naloxone film	24mg	3 sublingual films
Zubsolv	17.1mg-4.2mg	2 sublingual tablets

Criteria for Approval: *(Must be met for all requests)*

- ❑ Diagnosis of Opioid Use Disorder (OUD). Chart Note Page #: _____

Criteria for Approval: *(At least **one** of the following must be met)*

- ❑ Patient must be pregnant. Estimated delivery date: _____ Chart Note Page #: _____
- ❑ Patient is a rapid drug metabolizer previously identified by genetic testing. Submitted notes page #: _____
- ❑ Concurrent OUD treatment with CYP3A4 inducers, affecting medication metabolism. Chart Note Page #: _____
- ❑ Induction phase for single-agent buprenorphine products (approval up to 14 days). Chart Note Page #: _____
- ❑ Temporary acute pain management during OUD treatment (approval up to 14 days). Chart Note Page #: _____
- ❑ Inadequate response to treatment within dose and/or qty limits.
  Duration Requested: _____ Chart Note Page #: _____

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Trial and failure of preferred product in same PDL class or prescriber must demonstrate medical necessity for a non-preferred product. Details: _____ Chart Note Page #: _____

Authorization Period: Up to six (6) months
Re-authorization: Up to one (1) year. No re-authorization for temporary pain management.

Notes:

- UT Medicaid aligned with the American Society of Addiction Medicine National Practice 2020 guidelines to recommend psychosocial treatment in conjunction with medications for the treatment of, or prevention of relapse to, opioid use disorder.

PROVIDER CERTIFICATION

I attest the information provided is true and accurate to the best of my knowledge and included in the patient's medical record.

_____ _____

Prescriber's Signature Date