

# SUBOXONE (buprenorphine and naloxone)

## PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

**Please circle the appropriate answer for each applicable question (Y for Yes, N for No).**

1. Is the drug being requested Subutex? Y    N  
[If the answer to this question is no, then skip to question 3.]
2. Is the member a pregnant female? Y    N
3. Has the member been receiving Suboxone or Subutex? Y    N  
[If the answer to this question is no, skip to question 6.]
4. Is the member receiving any other opioids? Y    N
5. Will the prescriber evaluate the following? Y    N
  - Random urine drug screen
  - Assessment of member's progress (e.g. relapse, progress/accomplishment of treatment goals)
6. Is the member 16 years of age or older? Y    N
7. Does the member have the diagnosis of opioid dependence? Y    N
8. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone and Subutex? Y    N  
[If yes, provide registration number.]

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9. Is the prescription part of an overall treatment program? Y      N  
(e.g. self-help groups, counseling, provide ongoing care, vocational training)

**Comments:**

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*I affirm that the information given on this form is accurate as of this date.*

**Prescriber (or Authorized) Signature and Date:**

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