Buprenorphine & Buprenorphine/Naloxone Prior Authorization Form

West Virginia Public Employees Insurance Agency
Drug Prior Authorization Form

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last)	(First)	(MI)	Date of Birth (MM/DD/YYYY)

Prescriber Name (Last)	(First)	(MI)

Prescriber Address (Street)	(City)	(State)	(Zip)

Prescriber 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)

Prescriber DEA-X # (required)

Pharmacy Name (if applicable)

Pharmacy Address (Street)	(City)	(State)	(Zip)

Pharmacy 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

☐ Bunavail® buccal film ☐ Zubsolv® sublingual tablet
☐ Suboxone® sublingual film
☐ Suboxone® sublingual tablet Strength: _____

☐ Subutex® (approved only during pregnancy) Expected Delivery Date: (MM/DD/YYYY)
☐ 2mg ☐ 8mg

Directions	Diagnosis	ICD Diagnosis Code (required)

☐ Yes ☐ No I have reviewed the WV Board of Pharmacy Prescription Drug Monitoring Program database for this patient. (required)

List other sedating medications the patient is currently taking (e.g., muscle relaxants, antidepressants, sedative/hypnotics)

Sedating Medications: Diagnosis:

☐ Yes ☐ No I have warned the patient about dangers of combining Buprenorphine & Buprenorphine/Naloxone with other sedating medications and/or alcohol. (required)

☐ Yes ☐ No I certify that I have not charged cash for this office visit or for the treatment of this patient's opiate dependence/addiction. (required)

Other Pertinent Information (attach additional pages)

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Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.	☐ Check here for electronic signature
Prescriber Signature:	Date: (MM/DD/YYYY)