

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)	
<p>Confidentiality Notice: This document contains confidential health information that is protected by law. This information is intended only for the use of the individual or entity named above. The intended recipient of this information should destroy the information after the purpose of its transmission has been accomplished or is responsible for protecting the information from any further disclosure. The intended recipient is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately by telephone at (800) 847-3859 and arrange for the return or destruction of these documents. Thank you.</p>				
<p>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.</p>				
<input type="checkbox"/> Bunavail® buccal film <input type="checkbox"/> Suboxone® sublingual film <input type="checkbox"/> Suboxone® sublingual tablet	<input type="checkbox"/> Zubsolv® sublingual tablet Strength: _____	<input type="checkbox"/> Subutex® <small>(approved only during pregnancy)</small> <input type="checkbox"/> 2mg <input type="checkbox"/> 8mg	Expected Delivery Date: (MM/DD/YYYY)	
Directions		Diagnosis		ICD Diagnosis Code (required)
<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____				
<input type="checkbox"/> Yes <input type="checkbox"/> No I have warned the patient about dangers of combining Buprenorphine & Buprenorphine/Naloxone with other sedating medications and/or alcohol. (required)				
<input type="checkbox"/> Yes <input type="checkbox"/> 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)