



SUBOXONE RENEWAL

PRIOR AUTHORIZATION REQUEST FORM

****SUBMIT PRIOR AUTHORIZATION TO ENVISION RX OPTIONS • PHONE: 855-872-0005 • FAX: 877-503-7231****

GENERAL INFORMATION

Patient Name:			Date of birth:
Patient Address:			Patient Phone #:
City	State	Zip	Member ID #:

PHYSICIAN INFORMATION

Physician Name:			Practice type: ☐ PCP ☐ Specialty_____
Practice Address:			Physician NPI:
City	State	Zip	Prescriber 'X' DEA #:

SECTION I: TREATMENT INFORMATION

Drug Name: Suboxone Film	Strength:	Directions:	Quantity:
Is the total daily dose being prescribed for Suboxone (buprenorphine/naloxone) greater than 16mg/4mg per day? ☐ Yes ☐ No		Is the continuation therapy an attempt at a step down dose? ☐ Yes ☐ No	
Does the patient have any untreated or unstable psychiatric conditions that may interfere with compliance? ☐ Yes ☐ No If yes, list the conditions:_____			
Does the prescriber of the Suboxone (buprenorphine/naloxone) attest that the patient had consistent participation in a substance abuse or behavioral health program, behavioral health counseling, an addictions recovery program, or the Suboxone "Here to Help program?" ☐ Yes ☐ No ☐ Unknown			

SECTION II: URINE DRUG SCREENS

Please provide at least 2 random drug screenings (with at least 1 of those screenings within the last 3 months). COPIES MUST BE PROVIDED FOR APPROVAL.

Are two random drug screens attached? ☐ Yes ☐ No	Is the date of one of the random drug screenings within the last 3 months? ☐ Yes ☐ No
Are both drug screens provided negative for tested drugs? ☐ Yes ☐ No	If the drug screen is positive, please provide steps being taken to address member's non-compliance program. Were these steps provided as supporting documentation? ☐ Yes ☐ No

SECTION III: COVERAGE NOTES

VPHP covers up to 24/6 mg per day for the first 60 days of treatment. After this initial period, no more than 16/4 mg per day may be covered. THERE IS A 16MG/4MG QUANTITY LIMIT IN PLACE.

Upon approval, the patient will automatically be **locked in** for Suboxone to the physician requesting authorization.

SUBMISSION INSTRUCTIONS

(Please attach any additional medical justification)

FAX. You may fax the completed form to
EnvisionRxOptions at 877-503-7231

☐ **Expedited/Urgent**

Physician Signature

Date