

**BUPRENORPHINE 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: Buprenorphine Tablets	Strength:	Directions:	Quantity:
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IS THE TOTAL DAILY DOSE BEING PRESCRIBED FOR BUPRENORPHINE GREATER THAN 16MG PER DAY? ☐ Yes ☐ No	IS THE CONTINUATION THERAPY AN ATTEMPT AT A STEP DOWN DOSE? ☐ Yes ☐ No
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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 Buprenorphine 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

Is the member pregnant?

☐ Yes ☐ No ☐ MALE

If yes, anticipated date of delivery: _____

Is the member breastfeeding?

☐ Yes ☐ No ☐ MALEDoes the member have a documented allergic reaction or intolerance to naloxone? ☐ Yes ☐ No**If yes, provide medical records (FDA MedWatch Form) documenting the reaction.**If you answered "No" to the questions above, what is the medical necessity for prescribing Buprenorphine, rather than Suboxone (buprenorphine/naloxone), for this member?
_____**SECTION II: URINE DRUG SCREENS****Please provide at least two random drug screens, with at least 1 of those screenings dated within the last 3 months. COPIES OF TWO DRUG SCREENS MUST BE PROVIDED FOR APPROVAL.****ARE TWO RANDOM DRUG SCREENS ATTACHED?**☐ Yes ☐ No**IS THE DATE OF AT LEAST ONE OF THE RANDOM DRUG SCREENS WITHIN THE LAST 3 MONTHS?** ☐ Yes ☐ No

Are both drug screens provided negative for tested drugs?

☐ Yes ☐ NoIf 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 Buprenorphine 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