BlueCross BlueShield Federal Employee Program®

SUBOXONE
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select strength(s) being requested and provide quantity:

Bunavail film (buprenorphine/naloxone)
- ❑**2.1mg/0.3mg qty_____ per 90 days**
- ❑**4.2mg/0.7mg qty_____ per 90 days**
- ❑**6.3mg/1mg qty_____ per 90 days**

Buprenorphine SL tablet
- ❑**2mg qty_____ per 90 days**
- ❑**8mg qty_____ per 90 days**

Suboxone (buprenorphine/naloxone)
- ❑**2mg/0.5mg qty_____ per 90 days**
- ❑**4mg/1mg qty_____ per 90 days**
- ❑**8mg/2mg qty_____ per 90 days**
- ❑**12mg/3mg qty_____ per 90 days**

Zubsolv tablet (buprenorphine/naloxone)
- ❑**0.7mg/0.18mg qty_____ per 90 days**
- ❑**1.4mg/0.36mg qty_____ per 90 days**
- ❑**2.9mg/0.71mg qty_____ per 90 days**
- ❑**5.7mg/1.4mg qty_____ per 90 days**
- ❑**8.6mg/2.1mg qty_____ per 90 days**
- ❑**11.4mg/2.9mg qty_____ per 90 days**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   - ❑Opioid dependence
   - ❑Other diagnosis ***(please specify)***: _____

2. Will this medication be taken in combination with another opioid, either long acting (ER/LA/SA) or immediate acting (IR)? ❑Yes* ❑No
   - ****If YES***, do you agree the patient will be tapered off other opioids within 30 days? ❑Yes ❑No

3. Is the patient using this medication exclusively for pain control? ❑Yes ❑No

4. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

   ❑**INITIATION** of therapy, please answer the following questions:
   - a. Will the patient receive counseling and psychosocial support? ❑Yes ❑No
   - b. Will the patient be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential diversion to others? ❑Yes ❑No

   ❑**CONTINUATION** of therapy (**PA renewal**), please answer the following questions:
   - a. Is this medication being used for the maintenance treatment of opioid dependence? ❑Yes ❑No
   - b. Has the patient shown signs of opioid dependence-relapse? ❑Yes ❑No
   - c. Will the monitoring of therapy and support be continued? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Suboxone – FEP MD Fax Form Revised 5/9/2025