



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: <input type="checkbox"/> Male <input type="checkbox"/> 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) <input type="checkbox"/> 2.1mg/0.3mg qty _____ per 90 days <input type="checkbox"/> 4.2mg/0.7mg qty _____ per 90 days <input type="checkbox"/> 6.3mg/1mg qty _____ per 90 days	Buprenorphine SL tablet <input type="checkbox"/> 2mg qty _____ per 90 days <input type="checkbox"/> 8mg qty _____ per 90 days
Suboxone (buprenorphine/naloxone) <input type="checkbox"/> 2mg/0.5mg qty _____ per 90 days <input type="checkbox"/> 8mg/2mg qty _____ per 90 days <input type="checkbox"/> 4mg/1mg qty _____ per 90 days <input type="checkbox"/> 12mg/3mg qty _____ per 90 days	
Zubsolv tablet (buprenorphine/naloxone) <input type="checkbox"/> 0.7mg/0.18mg qty _____ per 90 days <input type="checkbox"/> 5.7mg/1.4mg qty _____ per 90 days <input type="checkbox"/> 1.4mg/0.36mg qty _____ per 90 days <input type="checkbox"/> 8.6mg/2.1mg qty _____ per 90 days <input type="checkbox"/> 2.9mg/0.71mg qty _____ per 90 days <input type="checkbox"/> 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

- What is the patient's diagnosis?
☐ Opioid dependence
☐ Other diagnosis (*please specify*): _____
- 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
- Is the patient using this medication exclusively for pain control? ☐ Yes ☐ No
- Is this request for **INITIATION** or **CONTINUATION** of therapy? *Please select answer below:*
☐ **INITIATION** of therapy, please answer the following questions:
 - Will the patient receive counseling and psychosocial support? ☐ Yes ☐ No
 - 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:
 - Is this medication being used for the maintenance treatment of opioid dependence? ☐ Yes ☐ No
 - Has the patient shown signs of opioid dependence-relapse? ☐ Yes ☐ No
 - Will the monitoring of therapy and support be continued? ☐ Yes ☐ No