Nebraska Buprenorphine/Naloxone, Buprenorphine, and Suboxone Tab
Prior Authorization Request Form

Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-877-276-9630

Member Information			Provider Information		
Member Name:			Provider Name:		
Member ID:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information		
Medication Name (Circle one): Buprenorphine/Naloxone Film Buprenorphine Tablet Buprenorphine/Naloxone Tablet Suboxone Tablet	Strength:	Quantity per day:
☐ Check if requesting for **continuation of therapy**	Duration requested: (Max is 12 months)	

Required Clinical Information
****please submit all required clinical notes/consent form in reference to this request****

Select the diagnosis below:
☐ Opioid dependence
☐ Other diagnosis: ___________________________________ ICD-10 Code(s):________________________________

BUPRENORPHINE/NALOXONE, BUPRENORPHINE, & SUBOXONE ARE NOT COVERED FOR PAIN MANAGEMENT

1) Has the provider been issued an "X" DEA number? ☐ Yes ☐ No
2) Has the patient failed treatment with the preferred product: Suboxone FILM? ☐ Yes ☐ No
3) Does the patient have other opioid (including tramadol) or benzodiazepine medications prescribed at time of buprenorphine initiation? (must be discontinued for authorization). ☐ Yes ☐ No
4) Has the patient signed a contract (*or Informed Consent*)? (Attach either clinic standard form or WellCare form). ☐ Yes ☐ No
5) Is the patient pregnant or nursing? ☐ Yes ☐ No
   If Yes; Expected delivery date _________________
6) For renewal:
   Has patient been compliant with contract (*or Informed Consent*) and had appropriate random urine drug screening results? ☐ Yes ☐ No ☐ N/A

By signing below, you attest that all statements on this form are true to the best of your knowledge

Prescribers Signature:____ **Date:**________________________________

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