NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
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Opioid Dependence Therapy Agents PA Request Form

Use this form to request coverage for Bunavail, buprenorphine/naloxone tablets, Zubsolv, and buprenorphine tablets

Suboxone Film and Sublocade do not require Prior Approval

Beneficiary Information

1. Beneficiary Last Name:________________________________2. First Name:_______________

3. Beneficiary ID #:___________4. Beneficiary Date of Birth:__________5. Recipient Gender:__________

Prescriber Information

6. Prescribing Provider NPI#:_______________6a. Requester Contact Information. Name:____________Phone #:_______

Please answer 7a, 7b and 7c for all PA requests

7a. Does the beneficiary have a diagnosis of Opioid Dependence? Yes__No__

7b. What is the total daily dose of the opioid dependence therapy agent being requested?_____________mg/day

7c. Has the Provider reviewed the Controlled Substances Reporting System Database prior to writing the prescription to ensure that concomitant opioid or use is not occurring? Yes__No____

Bunavail, Zubsolv, buprenorphine/naloxone tablets (questions 8-10)

8. Name of Medication requested:_________________8a. Strength:_________8b. Quantity per 30 days _____

8c. Requested Duration ________

9. Has the beneficiary tried and failed on Suboxone Film? Yes_____No_____

10. If the beneficiary has not tried and failed on Suboxone Film, please describe the clinical reason the beneficiary cannot use Suboxone Film.

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buprenorphine tablets (questions 11-16a)

11. Strength:___________11a. Quantity per 30 days_______11b. Requested Duration _________

12. Is the beneficiary unable to take Suboxone Film? Yes_____No_____

13. Is the beneficiary pregnant? Yes___ No_____13a. Is documentation attached? Yes_____No_____

14. If the beneficiary is pregnant, what is the estimated due date?_______**(approvals can be granted for up to 9 months)**

15. Is the beneficiary nursing? Yes___No_____**(approvals can be granted in 2 month intervals)**

16. Does the beneficiary have an allergy to naloxone with rashes, hives, pruritus, bronchospasm, angioneurotic edema, or anaphylactic shock? Yes_____No_____16a. Is documentation attached? Yes_____No_____

Signature of Prescriber:____Date: __________________

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**