GEISINGER HEALTH PLAN®

Buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®) Prior Authorization Request Form

IF REQUEST IS MEDICALLY URGENT, PLEASE CALL 1-800-988-4861 or fax to 570-271-5610, MONDAY-FRIDAY 8am-5pm

Medical documentation may be requested. This form will be returned if not completed in full.

Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
Member ID#:			NPI# (if available):		
Address:			Address:		
City:	State:		City:		State:
Home Phone:	Zip:		Office Phone #:	Office Fax #:	Zip:
Sex (circle): M F	DOB:		Contact Person:		

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
☐ New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty:
Height/Weight:	Drug Allergies:	Diagnosis:
Prescriber's Signature:		Date:

Criteria for Prior Authorization
FORM CANNOT BE PROCESSED UNLESS ALL BELOW ARE COMPLETE

- If buprenorphine is being requested medical reason that buprenorphine/naloxone can't be used: _____
  _____
- Results of most recent lab screen, drugs present: ☐ Buprenorphine ☐ Other opiates ☐ Other controlled substances (list below)
  Screen Date: _____ If buprenorphine not present and opiates or other controlled substances present how is this being addressed? _____
  _____
- Patient has been adherent to buprenorphine or buprenorphine/naloxone therapy : ☐ Yes ☐ No
  If "No" how is this being addressed? _____
  _____
- If patient has been on therapy > 1 year and total daily buprenorphine dose is > 8 mg/day please provide rationale for dose:
  _____
  _____
- Patient has been referred to and is actively involved in formal counseling with a licensed behavioral health provider
  ☐ Yes ☐ No Name of counselor and/or facility: _____
  If "No" rationale for non-participation: _____
  _____

Request for Expedited Review

☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS]
→ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING FOR THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

For Health Plan internal use only:
Date received_____ Date reviewed_____ Request approved: Y / N / NA

Instructions for Completing the Form

1. Submit a separate form for each medication.

2. Complete **ALL** information on the form.
   NOTE: The prescribing physician should, in most cases, complete the form.

3. Please be sure to provide the physician address in a legible format, as it is required for notification.

4. Once form is completed, mail or fax to:

   Geisinger Health Plan
   Attn: Pharmacy Department 30-45
   100 N. Academy Avenue
   Danville, PA 17822
   Fax: 570-271-5610

Buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®) Prior Authorization Clinical Management Procedures*

The Health Plan's[1] Pharmacy Department maintains a process by which Health Care Providers can:

- Request precertification for Buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®)

Buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®) requests will be evaluated and a determination of coverage made utilizing all the following criteria:

1. Member's eligibility to receive requested services (enrollment in the plan, prescription drug coverage, specific exclusions in Member's contract)

2. Specific criteria listed on the form

Please note that initial authorization will be for 3 months and subsequent authorizations will be for 6 months.

A Quantity Limit of a 34-day supply per fill will apply.

* Please refer to the Health Plan's Provider Guide and Formularies for further information.

***Please note that the Prior Authorization process is an independent process and is not in conjunction with the Specialty Pharmacy Drug Program*.**

[1] Geisinger Health Plan and Geisinger Indemnity Insurance Company shall be collectively referred to as "Health Plan."