



Prior Authorization Form

Buprenorphine and Naloxone (SUBOXONE®)/Buprenorphine (SUBUTEX®)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Initial Authorization request / Re-Authorization request
Drug Requested: (check one)
Suboxone / Subutex / Other
Dose / Quantity/Day supply
Date / Patient ID# / DOB
Patient Name / Provider NPI
Prescribing Physician / Office Contact
Office Fax # / Office Phone

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

Opioid dependence
Other (specify)

2. PATIENT HISTORY:

a. Does the provider have a Drug Addiction Treatment Act (DATA) waiver? Yes No*

Special identification number must be provided here:

b. Is the medication going to be used for induction phase treatment? Yes No N/A

c. Does the patient have contraindication/intolerance to Suboxone? Yes No N/A

d. Is the patient pregnant? Yes No N/A

RE-AUTHORIZATION REQUESTS ONLY:

e. Does the patient participate in comprehensive addiction care...? Yes No

f. Has the patient had a urine toxicology screen? Yes No N/A

Please add any other supporting medical information that may be useful in the decision-making process:

Blank lines for additional medical information

FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

* If prescriber does not have a DATA waiver number, documentation must be provided that prescriber has applied for it