Prescriber Criteria Form

Buprenorphine SL 2024 PA Fax 1391-A v1 010124.docx
Buprenorphine sublingual tablets
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Buprenorphine sublingual tablets.

Drug Name:
Buprenorphine sublingual tablets

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of opioid use disorder? [If no, then no further questions.]	Yes	No
2	Is the patient pregnant or breastfeeding? [If no, then skip to question 4.]	Yes	No
3	Is the requested drug being prescribed for induction therapy and/or subsequent maintenance therapy for treatment of opioid use disorder? [No further questions.]	Yes	No
4	Is the requested drug being prescribed for INDUCTION THERAPY for transition from opioid use to treatment of opioid use disorder? [If yes, then no further questions.]	Yes	No
5	Is the requested drug being prescribed for maintenance therapy for treatment of opioid use disorder in a patient who is intolerant to naloxone?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____