TUFTS Health Plan

Tufts Health RITogether
Buprenorphine/Naloxone (Suboxone, Bunavail, Zubsolv)
Medication Request Form

Please fax form to: 617.673.0988

Today's date: _____/_____/_____

*This medication request applies to members of **Tufts Health RITogether** (RI Medicaid Plan). Participating providers should use this form to request authorization for buprenorphine/naloxone medications. Generic buprenorphine/naloxone sublingual tablets are the preferred product and are covered with a quantity limit. Please call **844.301.4093** with any questions about medications.*

Member/prescriber information

Member name: _____ Prescriber name: _____

Member ID#: _____ Prescriber specialty: _____

Member DOB: _____ xDEA# (required): _____

NPI#: _____ Prescriber Phone #: ( ) _____

Prescriber Fax #: ( ) _____

Medication information

Drug Name: Buprenorphine/naloxone

☐ Generic Tablets ☐ Bunavail
☐ Suboxone ☐ Zubsolv

Duration: _____ Strength & Frequency: _____

Treatment status: ☐ New start ☐ Re-initiation ☐ Continuation of therapy

Clinical information

Diagnosis: ☐ Opioid addiction ☐ Other, please specify: _____

Does the member's treatment plan include ongoing participation in a structured drug addiction treatment program and/or counseling? ☐ Yes ☐ No

If the request exceeds the quantity limit, please provide rationale for a dosing regimen that exceeds the recommended maintenance dose with *one* of the following:

- ☐ Current tape schedule:_____
- ☐ Recent taper trial: _____ Date: _____/_____/_____ Trial dose: _____

  Response: _____
- ☐ Rationale for not tapering: _____

  Anticipated date of next taper: Date: _____/_____/_____

Forms available at tuftshealthplan.com/provider
Tufts Health Public Plans Rhode Island provider services number: 844.301.4093
6234B 01028
RxUM_RIT_201801

TUFTS Health Plan

Tufts Health RITogether
Buprenorphine/Naloxone (Suboxone, Bunavail, Zubsolv)
Medication Request Form
Please fax form to: 617.673.0988

If the request is for brand-name Bunavail, Suboxone film, Zubsolv, please answer the following:

Did the patient have an allergic reaction to an ingredient in the generic formulation? ☐ Yes ☐ No
If yes, please indicate the allergen: _____

Did the patient have an adverse reaction associated with the generic tablets? *If yes, please describe*: ☐ Yes ☐ No
_____

Is there a need for micro-tapering below 8 mg/day? ☐ Yes ☐ No

Is there concern with child safety? *If yes, please describe*: ☐ Yes ☐ No

Other history relevant to this request:
_____
_____
_____
_____
_____
_____

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.

Prescriber Signature: _____ Date: _____

Forms available at tuftshealthplan.com/provider
Tufts Health Public Plans Rhode Island provider services number: 844.301.4093
6234B 01028
RxUM_RIT_201801