TUFTS Health Plan

Tufts Health RITogether
Buprenorphine Sublingual Tablets (Subutex)
Medication Request Form
Please fax form to: 617.673.0988

Today's date: _____/_____/_____

*This medication request form applies only to members of **Tufts Health RITogether** (RI Medicaid plan). Participating providers should use this form to request authorization for buprenorphine SL (Subutex) tablet. Please call us at **844.301.4093** with any questions about medication requests.*

We can only process completed form

Member information	**Prescriber Information**
Last name:_____	Last name:_____
First name:_____	First name:_____
Member ID#:_____	Specialty:_____
Member DOB: _____/_____/_____	xDEA# (required):_____
	NPI#:_____
	Prescriber phone:_____
	Prescriber fax:_____

Medication information

Drug name: Buprenorphine SL Tablets (Subutex)

Strength, Frequency, Duration: _____

Clinical information

Diagnosis: ☐ Opioid addiction or dependence ☐ Other, specify: _____

The request is for: *Check one*

- ☐ Induction
- ☐ Pregnancy/nursing: Estimated due date/anticipated nursing date: _____/_____/_____
- ☐ Contraindication (e.g. suboxone, naloxone), please specify: _____
- ☐ Other: please specify: _____

Does your treatment plan include any of the following? *Check all that apply.*

- ☐ Psychosocial support (i.e., counseling and/or treatment groups)
- ☐ Routine office visits
- ☐ Dose taper ☐ Toxicology screening ☐ Duration of Buprenorphine Treatment
- ☐ Other, please specify: _____

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 (STAMP NOT ACCEPTED) *Date*

Forms available at tuftshealthplan.com/provider
Tufts Health Public Plans provider services number: 844.301.4093
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