TUFTS Health Plan

Tufts Health Together
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 Together** (MassHealth Plan). Participating providers should use this form to request authorization for buprenorphine/naloxone medications. Suboxone (buprenorphine/naloxone) sublingual films are the preferred product and are covered with a quantity limit. Please call **888.257.1985** with any questions about medications.*

Member / prescriber information

Member name: _____

Member ID#: _____

Member DOB:_____

NPI#: _____

Prescriber name: _____

Prescriber specialty: _____

xDEA# (required): _____

Prescriber Phone #: ( ) _____

Prescriber Fax #: ( ) _____

Medication information

Drug Name: Buprenorphine/naloxone

☐ **Suboxone SL film (preferred)**
☐ Generic tablets ☐ Bunavail ☐ 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 provider services number: 888.257.1985
6234A 01028
RxUM_MAT_201801

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If the request is for buprenorphine/naloxone generic tablets, brand-name Bunavail, or Zubsolv, please answer the following:

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

Did the patient have an adverse reaction associated with the Suboxone films that cannot be managed? ☐ Yes ☐ No
If yes, please describe:
_____

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

By checking the following box, I certify that applying the standard review time frame may seriously jeopardize my patient's life, health, or ability to attain, maintain, or regain maximum function. ☐ Request for expedited review

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: _____

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