



Mail Requests To: Cigna
 8455 University Place # HQ2L-04
 St. Louis, MO 63121
 Fax Requests To: (866) 845-7267
 Request By Phone: (877) 813-5595

**Buprenorphine SL tabs, Buprenorphine/Naloxone SL tabs, Suboxone Film
 and Zubsolv tabs Coverage Determination
 (FOR PROVIDER USE ONLY)**

MEMBER INFORMATION REQUIRED (Please Write Legibly)	
Customer Name:	Customer ID:
Customer DOB:	Customer Address:
Phone (Home):	Phone (Cell):

PROVIDER INFORMATION REQUIRED (Please Write Legibly)		
License Number:	DEA Number:	NPI Number:
Provider Name:	Provider Address:	
Provider Phone:	Provider Fax:	
Provider Specialty:	Office Contact Name:	

DRUG & PRESCRIPTION INFORMATION REQUIRED (Please Write Legibly)	
Drug Name: _____	Dosage: _____
Frequency: _____	Quantity: _____ Days Supply: _____ Refills: _____
<input type="checkbox"/> Do Not Substitute-Dispense As Written	<i>Please check whether this is a new medication or therapy continuation</i>
	<input type="checkbox"/> New Medication <input type="checkbox"/> Continuation If you have checked "Continuation", Provide Start Date-----> _____

SELECT DIAGNOSIS
<input type="checkbox"/> Opioid Dependence List Diagnosis/ICD-10 Code(s): _____



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ATTENTION: FAILURE TO PROVIDE CLINICAL INFORMATION SUPPORTING RATIONALE MAY RESULT IN THIS REQUEST BEING DENIED, OR AN ADDITIONAL OUTREACH TO OBTAIN MISSING CLINICAL INFORMATION.

APPROVALS FOR BUPRENORPHINE SUBLINGUAL TABLETS ARE LIMITED UP TO A 30 DAY SUPPLY OF BUPRENORPHINE INDUCTION THERAPY, FOLLOWED BY MAINTENANCE THERAPY ON BUPRENORPHINE/NALOXONE UNLESS THE CUSTOMER MEETS ONE OF THE FOLLOWING CRITERIA:

- Is the customer pregnant? YES NO
- Has the customer experienced a hypersensitivity reaction to naloxone? YES NO

If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to why an exception should be made:

Is the request for an inpatient that is awaiting discharge? YES NO

BUPRENORPHINE SL TABS, BUPRENORPHINE/NALOXONE SL TABS, SUBOXONE FILM AND ZUSOLV TABS HAVE A QUANTITY LIMIT OF 90 PER 30 DAYS. IF A GREATER QUANTITY IS REQUESTED PLEASE ANSWER THE QUESTIONS BELOW.

Has the customer tried and failed a lower dose (please document below)? YES NO

If lower dosing was not tried, please provide clinical explanation as to why dosing within the quantity limit would be ineffective, cause adverse effect or negatively impact medication compliance.

Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum function

Provider Signature: _____ **Date:** _____

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