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:_____

☐ ***Do Not Substitute-Dispense As Written***

*Please check whether this is a new medication or therapy continuation*

☐ **New Medication** ☐ **Continuation**

If you have checked "Continuation",
Provide Start Date--------->_____

## SELECT DIAGNOSIS

☐ **Opioid Dependence**

**List Diagnosis/ICD-10 Code(s):** _____

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## (FOR PROVIDER USE ONLY)

**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 ZUBSOLV 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:**