Transmucosal Buprenorphine

Please fax this completed form to (866) 399-0929 OR mail to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720.

Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, is there documentation of a positive clinical benefit? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Moderate to severe opioid use disorder
   ☐ Other. Specify: _____

3. Select from the following for your patient and complete associated question(s):

   ☐ Patient is pregnant. Estimated delivery date (EDD):_____
   Was pregnancy confirmed with a lab test by the provider? ☐ Yes ☐ No
   Is buprenorphine prescriber managing patient's pregnancy? ☐ Yes ☐ No
   Has patient been stable on buprenorphine/naloxone for at least 8 weeks? ☐ Yes ☐ No

   ☐ Patient is breastfeeding. Delivery date: _____

   Patients approved based on breastfeeding, will be approved for 12 months following delivery. Transition to a buprenorphine/naloxone combination product is required for ongoing treatment thereafter.

   ☐ Patient has experienced a documented serious allergic or idiosyncratic reaction to the buprenorphine/naloxone combination product. **Chart notes documenting reaction are required.**

   ☐ Patient has continued to experience severe nausea or daily headache after a 7day trial of buprenorphine/naloxone sublingual tablet and sublingual film formulations.
   Indicate formulations tried for at least 7 days (check all that apply):
   ☐ Sublingual film
   ☐ Sublingual tab

4. **Best practice is to limit patients to a 7-day supply at a time for the first month of treatment.**
   Indicate the intended day supply per fill for your patient: ☐ 7 day ☐ 14 day ☐ 28 day

   If over a 7 day supply is indicated:
   - Is the reason due to transportation complications? ☐ Yes ☐ No
     If no, provide reason: _____
   - Has patient demonstrated evidence of stability (8 weeks of treatment) taking buprenorphine monotherapy or buprenorphine/naloxone? ☐ Yes ☐ No
     If yes, how long has patient been clinically stable? _____

Prescriber signature	Prescriber specialty	Date

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)