

APPLIES TO COMMERCIAL AND MEDICAID
Health New England
Medication Request Form (MRF)
Suboxone® (buprenorphine/Naloxone)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Suboxone®. Please complete this form and fax to MedMetrics Health Partners at (800) 550-9246. If you have any questions regarding this process, please contact MedMetrics clinical call center at (866) 209-1057.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Area Code and Telephone #: () -
Diagnosis:	Area Code and Fax #: () -

Drug Information			
Requested Drug / Strength: <input type="checkbox"/> Suboxone	<ul style="list-style-type: none"> HNE has a quantity limit of a combined total of 90 tablets per 30 day period for 2-0.5mg and 8-2mg tablets 		
Dose, directions and length of treatment (please be specific):	Quantity:	Refills:	
Physician signature:	Date:		
Indication: <input type="checkbox"/> Opioid Dependence			
Initial authorization <input type="checkbox"/> Documentation of treatment plan <input type="checkbox"/> Provider is part of the suboxone registry			
Reauthorization: The following clinical information will be required for reauthorization <input type="checkbox"/> Documentation of effectiveness and treatment plan			