North Carolina Department of Health and Human Services
Division of Medical Assistance
Opioid Dependence Therapy Agents Temporary PA Request Form

Use this form to request coverage for Bunavail, buprenorphine/naloxone tablets, Zubsolv, and buprenorphine tablets

Suboxone Film does not require Prior Approval

Beneficiary Information
1. Beneficiary Last Name: ____________________________________________ 2. First Name: ____________________________ 

Prescriber Information
6. Prescribing Provider NPI#: ____________________ 6a. Requester Contact Information. Name: __________________ Phone #: ________

Please answer 7a. and 7b for all PA requests
7a. Has the Provider reviewed the Controlled Substances Reporting System Database prior to writing the prescription to ensure that concomitant opioid or use is not occurring? Yes No
7b. What is the total daily dose of the opioid dependence therapy agent being requested? _____________mg/day

Bunavail, Zubsolv, buprenorphine/naloxone tablets (questions 8-10)
8. Name of Medication requested: _________________ 8a. Strength: __________ 8b. Quantity per 30 days ______
8c. Requested Duration __________
9. Has the beneficiary tried and failed on Suboxone Film? Yes _____ No ______
10. If the beneficiary has not tried and failed on Suboxone Film, please describe the clinical reason the beneficiary cannot use Suboxone Film. _____________________________________________________________

buprenorphine tablets (questions 11-17a)
11. Strength: __________ 11a. Quantity per 30 days ________ 11b. Requested Duration ________
12. Does the beneficiary have a diagnosis of opioid dependence? Yes _____ No ______
13. Is the beneficiary unable to take Suboxone Film? Yes _____ No ______
14. Is the beneficiary pregnant? Yes ____ No _____ 14a. Is documentation attached? Yes No 
15. If the beneficiary is pregnant, what is the estimated due date? ________ (approvals can be granted for up to 9 months)
16. Is the beneficiary nursing? Yes ____ No ______ (approvals can be granted in 2 month intervals)
17. Does the beneficiary have an allergy to naloxone with rashes, hives, pruritus, bronchospasm, angioneurotic edema, or anaphylactic shock? Yes _____ No _____ 17a. Is documentation attached? Yes No

Signature of Prescriber: ___________________________________________ Date: _______________________

(Prescriber signature mandatory)
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.

This form can be uploaded into the secure NCTracks Provider Portal, faxed, or mailed to CSRA. If faxed, the Standard Drug Request Form MUST be the first page faxed.

Fax all forms and any attachments to CSRA at: (855) 710-1969. Pharmacy PA Call Center: (866) 246-8505.

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