

North Carolina Department of Health and Human Services  
**Division of Health Benefits**  
**Opioid Dependence Therapy Agents PA Request Form**

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

**Suboxone Film and Sublocade do not require Prior Approval**

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Recipient Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI#: \_\_\_\_\_ 6a. Requester Contact Information. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Please answer 7a, 7b and 7c for all PA requests**

- 7a. Does the beneficiary have a diagnosis of Opioid Dependence? Yes\_\_No\_\_  
7b. What is the total daily dose of the opioid dependence therapy agent being requested? \_\_\_\_\_mg/day  
7c. 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\_\_

**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 11-16a)**

11. Strength: \_\_\_\_\_ 11a. Quantity per 30 days \_\_\_\_\_ 11b. Requested Duration \_\_\_\_\_  
12. Is the beneficiary unable to take Suboxone Film? Yes \_\_\_\_\_ No \_\_\_\_\_  
13. Is the beneficiary pregnant? Yes \_\_\_ No \_\_\_ 13a. Is documentation attached? Yes \_\_\_\_\_ No \_\_\_\_\_  
14. If the beneficiary is pregnant, what is the estimated due date? \_\_\_\_\_ **(approvals can be granted for up to 9 months)**  
15. Is the beneficiary nursing? Yes \_\_\_ No \_\_\_\_\_ **(approvals can be granted in 2 month intervals)**  
16. Does the beneficiary have an allergy to naloxone with rashes, hives, pruritus, bronchospasm, angioneurotic edema, or anaphylactic shock? Yes \_\_\_\_\_ No \_\_\_\_\_ 16a. 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 NCTracks. Fax all forms and any attachments to NCTracks at: (855) 710-1969. Pharmacy PA Call Center: (866) 246-8505.**