Member ID#		Date Submitted			
Name		DEA# (including X)			
Phone		NPI #			
Dx		Prescriber Name			
Diagnosis		Phone		Fax	
SPECIALTY		Alternate Phone		Contact	

Form must be completed, signed and submitted by a physician with a Drug Addiction Treatment Act (DATA) waiver** (UIN #)

Drug Requested:

[ ] Suboxone® SL Film Tab 8mg/2mg [ ] Suboxone® SL Film Tab 2mg/0.5mg

[ ] buprenorphine SL Tab 8mg [ ] buprenorphine SL Tab 2mg

Quantity: _____ Sig: _____

Start date of this PA: _____

**Doses above 32 mg per day will NOT be approved.

1. Primary Diagnosis: ICD-9: _____
2. Psychosocial Counseling: _____
   a. Date of last psychosocial counseling session: _____
   b. Has patient been compliant with all sessions? [ ] Yes [ ] No
3. Please provide plan for method and dates (next 3) of psychosocial counseling going forward:
   a. Method: _____
   b. Dates: (1) _____ (2) _____ (3) _____
4. Must submit most current urine drug screen with this form.
5. Does patient currently abuse alcohol? [ ] Yes [ ] No
6. Has patient taken opioids in the past 30 days? [ ] Yes [ ] No
   a. If yes, please state reason for opioid use: _____
   b. If yes, has patient experienced a relapse in disease? [ ] Yes [ ] No
7. If requesting doses above 24 mg per day, state clinical reason current dosing limits are being exceeded: _____
   a. Has patient tried a dose of 16 mg per day? [ ] Yes [ ] No
   b. If yes, provide dates of therapy: _____
8. Please indicate a taper schedule if dose exceeds 16 mg/day buprenorphine: _____

_____

** I certify that I have a ***Drug Addiction Treatment Act (DATA) waiver.***

Physician Signature _____ **Date** _____

FAX to: WellCare Pharmacy 1-866-455-6558