

# Butrans (buprenorphine) Prior Authorization Request Form



5653

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) or the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> <li>The provider may <b>call: 1-866-684-4488</b> or the completed form may be <b>faxed to:</b> <b>1-866-684-4477</b></li> <li>The patient may attach the completed form to the prescription and <b>mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954</b> or <b>email</b> the form only to: <b>TpharmPA@express-scripts.com</b></li> </ul>
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Prior authorization criteria and a copy of this form are available at: [http://pec.ha.osd.mil/forms\\_criteria.php](http://pec.ha.osd.mil/forms_criteria.php). This prior authorization has no expiration date.

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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**Step 2** Please complete the clinical assessment:

1. Is Butrans being used for the treatment of opioid dependence?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to Question 2
2. Is Butrans being used to treat moderate to severe chronic pain requiring opioid therapy?	<input type="checkbox"/> Yes Proceed to Question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to Question 4	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
4. Are any of the following true: <ul style="list-style-type: none"> <li>patient requires more than 80 mg/day of morphine or equivalent for pain control?</li> <li>patient has significant respiratory depression or severe bronchial asthma?</li> <li>patient with long QT syndrome or family history of long QT syndrome?</li> <li>patient is on concurrent Class 1A (procainamide, quinidine) or Class III (dofetilide, amiodarone, sotalol) antiarrhythmics?</li> </ul>	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to Question 5
5. Is the request for the Butrans 5 mcg/hr patch?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Proceed to Question 6
6. Is the patient opioid tolerant (prior use of 30 mg/day to 80 mg/day of morphine [or equivalent], or Butrans 5 mcg/hr patch, within the past 60 days)?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Coverage not approved

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature	_____ Date
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