Butrans (buprenorphine)
Prior Authorization Request Form

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is Butrans being used for the treatment of opioid dependence?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to Question 2
2. Is Butrans being used to treat moderate to severe chronic pain requiring opioid therapy?	☐ Yes Proceed to Question 3	☐ No **STOP** Coverage not approved
3. Is the patient 18 years of age or older?	☐ Yes Proceed to Question 4	☐ No **STOP** Coverage not approved
4. Are any of the following true: • **patient requires more than 80 mg/day of morphine or equivalent for pain control?** • **patient has significant respiratory depression or severe bronchial asthma?** • **patient with long QT syndrome or family history of long QT syndrome?** • **patient is on concurrent Class 1A (procainamide, quinidine) or Class III (dofetilide, amiodarone, sotalol) antiarrythmics?**	☐ Yes **STOP** Coverage not approved	☐ No Proceed to Question 5
5. Is the request for the Butrans 5 mcg/hr patch?	☐ Yes Please sign and date below	☐ 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)?	☐ Yes Please sign and date below	☐ 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

Implementation: 4 Jan 2012

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: