Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Probuphine
(buprenorphine HCl)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
Probuphine 74.2mg: ☐ ICD10:

Quantity: Directions: J-Code:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:
Does your patient have a diagnosis of opioid dependence? ☐ Yes ☐ No
(if opioid dependence) Is your patient using this medication as part of a complete treatment plan that includes counseling and psychosocial support? ☐ Yes ☐ No
(if no) Please provide details of your patient's current treatment plan:

Is your patient using Probuphine for pain management? ☐ Yes ☐ No
(if yes) Please describe the diagnosis related to use and clinical rationale for the use of this drug in your patient.

During the 6 months that Probuphine is implanted, will your patient also be treated with opioid analgesics***? ☐ Yes ☐ No
****For example: Abstral, Actiq, Belbuca, buprenorphine, Butrans, codeine, Demerol, Dilaudid, Duragesic, Embeda, Exalgo, fentanyl, hydrocodone, hydromorphone, Hysingla ER, Kadian, Lazanda, meperidine, methadone, morphine, MS Contin, MSIR, Opana, Opana ER, oxycodone, oxymorphone, Reprexain, Roxicodone, Subsys, Vicoprofen, Xtampza, Xylon, Zohydro ER*

Has your patient been on ONE of the following drugs and dose for at least 3 months without any need for supplemental dosing or adjustments?
☐ buprenorphine sublingual tablet, 8mg or less per day
☐ buprenorphine-naloxone sublingual tablet, 8mg/2mg or less per day
☐ Bunavail buccal film, 4.2mg/0.7mg or less per day
☐ Suboxone sublingual film, 8mg/2mg or less per day
☐ Zubsolv sublingual tablet, 5.7mg/1.4mg or less per day
☐ none of the above

Is your patient able to use any of the following drugs? (check all that apply)

- ☐ buprenorphine sublingual tablets
- ☐ buprenorphine-naloxone sublingual tablets
- ☐ Bunavail
- ☐ Suboxone
- ☐ Zubsolv
- ☐ none of the above

Has your patient previously used Probuphine implant?

- ☐ no
- ☐ Yes, once before (1 time in one upper arm)
- ☐ Yes, twice before (1 time in EACH upper arm)
- ☐ Yes, more than twice before

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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