USFHP Prior Authorization Request Form For
Butrans (buprenorphine)

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) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire.

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 buprenorphine transdermal patch (Butrans) being used for the treatment of opioid dependence?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **2**
2. Is buprenorphine transdermal patch (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 buprenorphine transdermal patch (Butrans) 5 mcg/hr?	☐ Yes **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 buprenorphine transdermal patch (Butrans) 5 mcg/hr patch, within the past 60 days)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

Prescriber Signature _____ Date _____

[20 June 2025]