



**SUBOXONE / SUBUTEX NOTIFICATION FORM**

**Fax: (860) 907-2649 (Substance Abuse Only)**  
**Phone: (800) 953-8854 (Substance Abuse Only)**  
**Option #7**

**{Check this box if the member is followed by the Baltimore Buprenorphine Initiative}**

Date: \_\_\_\_\_ Total Pages: \_\_\_\_\_

Member Name: \_\_\_\_\_ ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Physicians/Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

(Print)

Is the member enrolled in a Substance Abuse / Mental Health Program?  Yes  No If Yes, name of the facility: \_\_\_\_\_

**Diagnosis for which the medication is being prescribed:**

**Medication / Strength / Dosing / Quantity / Duration:**

SUBOXONE

SUBUTEX

**Clinical information:**

Date Treatment Started: \_\_\_\_\_

Therapeutic Intervention (including frequency of counseling):

Prognosis:

Completed by: \_\_\_\_\_

Signature of prescribing Clinician: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_