



SUBOXONE / SUBUTEX OVERRIDE REQUEST 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: _____