Washington State Department of Labor & Industries

Buprenorphine Transdermal Patch Authorization Request Form

Office of the Medical Director
PO Box 44321
Olympia WA 98504-4321

Please fax the completed form along with any supportive medical documentation to:
360-902-6315 Attention: Drug Review Program.

Section 1:

Claim Number:	Injured Worker's Name:

Is chronic opioid therapy authorized?

☐ No — Stop. Buprenorphine transdermal patch is not authorized.
☐ Yes — Completed sections 2 — 4 below.

Section 2:

Indication for buprenorphine transdermal patch:

☐ Moderate to severe chronic pain, requiring continuous opioid analgesia.
☐ Other — Please specify:

_____

_____

Section 3:

A. Current opioid and daily dose: _____

B Highest opioid dose previously used to treat current condition: _____

C. Has the worker tried and failed at least **two** formulary opioids?

Formulary opioids: codeine, codeine with acetaminophen, hydrocodone with acetaminophen, hydrocodone with ibuprofen, hydromorphone, morphine IR/SR, oxycodone, oxycodone with acetaminophen, oxycodone with aspirin, oxymorphone, tramadol, and tramadol with acetaminophen.

Formulary opioid #1 _____ Date _____

Dose _____ Outcome _____

Formulary opioid #2 _____ Date _____

Dose _____ Outcome _____

If not, is there a medical contraindication to trials of formulary opioids?

☐ No — Use formulary opioids.
☐ Yes — Please specify:

Section 4

Prescriber name _____ Phone number _____

Signature _____ Date _____

RESET