

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

**TODAY'S HEALTH**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Oxycontin® OR Oxycodone Extended-Release Tablets: Prior Authorization Request Form: Please respond.

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- Please complete the attached Oxycontin® OR Oxycodone Extended-Release Tablets Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this drug**

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**Oxycontin® OR Oxycodone Extended-Release Tablets**

OxyContin® is no more effective than other extended-release opioids (e.g., morphine ER, fentanyl patch, methadone) in managing moderate to severe chronic pain but appears to have higher drug abuse potential. Additionally, off-label prescribing practices (e.g., dosing three or four times daily) is a growing problem that places patients at risk for drug-induced complications (e.g., sedation, CNS impairment). Methadone is recommended for use only by physicians experienced in methadone prescribing.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 01/24/2008

M0018\_PATEMP\_1107 CMS 11/28/07 H8742

# Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

### All items below this line are for Physician Use Only

#### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

#### Oxycontin® OR Oxycodone Extended-Release Tablets Criteria

- 1 Please select requested medication:  
 Oxycontin®                       Oxycodone ER
  - 2 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed  
 moderate to severe chronic pain, requiring continuous, around-the clock analgesia (indicate ICD-9) \_\_\_\_\_  
 Other (diagnosis and ICD-9) \_\_\_\_\_
  - 3 For patients requesting Oxycontin®: Is the patient receiving an immediate-release opioid for breakthrough pain in addition to an extended release product?  
 Yes     No
  - 4 Has the patient tried at least 2 of the following agents: morphine SR tabs, fentanyl patches, or methadone?  
 Yes     No
  - 5 Please list the dose, duration, and reason(s) for a subtherapeutic response and/or intolerance for each previously prescribed drug:  
 Oxycodone ER tablets \_\_\_\_\_  
 Morphine SR tablets \_\_\_\_\_  
 Kadian or Avinza \_\_\_\_\_  
 Fentanyl Patch \_\_\_\_\_  
 Methadone \_\_\_\_\_
- PLEASE NOTE: When switching to a formulary alternative, requested quantities above our limits Kadian (60 per 30 days) and Avinza (30 per 30 days), and Fentanyl patches (16 per 30 days) require submission of a Quantity Limit Request Form.

Medical justification: (Attach additional page if necessary): \_\_\_\_\_  
\_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_