



## PrimeWest Health Oxycodone Extended Release (OxyContin) Medication Request Form for Medical Assistance and MinnesotaCare programs

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Attn: Prior Authorization Department  
 10181 Scripps Gateway Court  
 San Diego, CA 92131  
 Phone: 1-800-788-2949  
 Fax: 1-858-790-7100

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

**Instructions**

Participating physicians and providers should use this form to request coverage for a formulary drug requiring prior authorization (PA), a non-formulary drug that has no suitable alternative, or any overrides of pharmacy management procedures such as step therapy, quantity limits, or other edits. Complete this form and fax it to PrimeWest Health at **1-858-790-7100**. Or call **1-877-391-9294** with this information. If you have any questions about this process, call PrimeWest Health at **1-877-391-9294**.

**Request for expedited (urgent) review:** By checking this box, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Medication Request Information (please complete each section of this form before sending) \*Denotes Required Fields**

PATIENT INFORMATION		PHYSICIAN INFORMATION	
*Name:		*Name:	
*ID#:		*Specialty:	
*Date of Birth:		ID#/DEA#:	
*Health Plan:		*Phone: (    )    -	*Fax: (    )    -
*Diagnosis (ICD-10 Code, if known):			
REQUESTED DRUG INFORMATION		PHARMACY INFORMATION	
*Requested Drug: oxycodone extended release (OxyContin)		Name:	
Dose:	Strength:	Phone: (    )    -	Fax: (    )    -
Quantity Prescribed (per month):	Directions:	Length of Treatment (please be specific):	

Reason for Medication Request (please be specific, give detail):

1. Is the medication prescribed to be used as needed (PRN)? .....  Yes  No
2. Is the medication prescribed more frequently than every 12 hours (twice daily)? .....  Yes  No
3. Is the patient 11 years or over (verified against date of birth)? .....  Yes  No
4. Is there a patient-specific pain management plan on file for the patient? .....  Yes  No
5. Has the prescriber confirmed the patient is not diverting the requested medication according to the patient's record in the state's prescription drug monitoring program (PDMP)? .....  Yes  No
6. Has the patient tried and failed an equivalent morphine extended release (ER) dose for at least 7 days? .....  Yes  No
7. Is the patient unable to use morphine ER for the any of the following reasons?
  - Patient has renal insufficiency (creatinine clearance < 60 ml/min).....  Yes  No
  - True morphine allergy (as manifested by skin rash, facial swelling, or difficulty swallowing) based on past history of morphine use .....  Yes  No
  - Patient develops morphine-related itching based on past history of morphine use .....  Yes  No
  - Morphine induces intolerable nausea and/or vomiting based on past history of morphine use .....  Yes  No
  - Patient is elderly (65 years or over), cachectic, or debilitated AND patient is at increased risk for morphine-induced respiratory depression .....  Yes  No
8. Is the patient receiving a combined daily dose of greater than 120 mg? .....  Yes\*  No
9. Does the patient have a diagnosis of cancer or is the member enrolled in a hospice program or meets hospice criteria for life expectancy of 6 months or less? .....  Yes  No
10. Is the patient undergoing treatment for chronic non-cancer pain? .....  Yes#  No
11. Please select the appropriate description of your specialty:
  - Oncologist .....  Yes  No
  - Specialist in chronic non-cancer pain.....  Yes  No
  - Specialist in the area of practice related to the source of the chronic non-cancer pain .....  Yes  No
  - Other \_\_\_\_\_...  Yes  No

Supplemental and required documentation submitted as applicable (\* and/or #) as separate documents:

- \*Documentation in support of therapy with a higher dose (quantity) for the intended diagnosis ...  Yes  No
- #Documentation of a formal, consultative evaluation for diagnosis and complete medical history, including previous pharmacological and non-pharmacological therapy .....  Yes  No