Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

OXYCONTIN
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested: OxyContin (oxycodone)	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Diagnosis:	Date Diagnosed:

For members age 11-17 please answer the following:

Has the member been on opioids for 5 consecutive days? □Yes □No

Will the member have been on a minimum of 20mg/day oxycodone equivalent on at least the 2 days prior to starting OxyContin therapy? □Yes □No

What is the anticipated duration of therapy ______________________

History of Medication History of Medications Used to Treat Above Condition

□ No other medications have been used to treat this condition

History of medications used to treat the above condition

Medication	Start Date	End Date	Strength	Frequency	Reason for Discontinuing
□ Fentanyl Patch					
□ Morphine Sulfate ER					
□ Opana ER					
□ Methadone					
□ Other					

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