



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Dolophine Post Limit (Medicare Prior Auth)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Dolophine Post Limit (Medicare Prior Auth).

Drug Name (select from list of drugs shown)

Dolophine

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State,

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

1. Is the methadone being prescribed for detoxification of a narcotic addicted patient? Y N
[If the answer to this question is yes, then no further questions are required.]
2. Is the methadone being prescribed as part of a methadone maintenance program? Y N
[If the answer to this question is yes, then no further questions are required.]
3. Does the patient require more than 240 tablets (5 mg and 10 mg) or 60 tablets (40 mg) per month? Y N
[If the answer to this question is no, a prior authorization is not required (these quantities are available without a prior authorization.)]
[NOTE: No authorization is required for up to 240 tablets (5 mg and 10 mg) or 60 tablets (40 mg) per month.]
4. Does the patient have the diagnosis of moderate to severe pain? Y N
[If the answer to this question is no, then no further questions are required.]
5. Is the patient tolerant to the analgesic effects of narcotics? Y N
[If the answer to this question is no, then no further questions are required.]
6. Does the patient have chronic or cancer pain requiring continual narcotic analgesia? Y N



**Arkansas
BlueCross BlueShield**

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7. Will the patient be monitored for respiratory depression during initiation of methadone and/or conversion of pain patients to methadone treatment from treatment with other opioid agonists and during dose titration?

Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date