Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Methadone, Methadose PL (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 Methadone, Methadose PL (Medicare Prior Auth).

Drug Name (select from list of drugs shown)

Methadone Methadose

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

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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.

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Prescriber (Or Authorized) Signature and Date