



Prior Authorization Form

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

Drug Name (select from list of drugs shown)

Oxycontin 60mg (oxycodone)

Oxycontin 80mg (oxycodone)

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. Does the patient require more than 320 mg in a 24-hour period? | Y | N |
| [If the answer to this question is no, then no prior authorization is required. Patients can receive up to 320 mg/day (four 80-mg tablets/day) without prior authorization.] | | |
| 2. Does the patient have a diagnosis of moderate to severe pain? | Y | N |
| 3. Is the patient being prescribed controlled-release oxycodone tablets (e.g. OxyContin) for continuous, around-the-clock pain relief? | Y | N |
| 4. Is the patient opioid tolerant? (Patients are considered opioid-tolerant if they have been taking at least 60 mg of morphine daily, at least 30 mg of oral oxycodone daily, or an equianalgesic dose of another opioid, for a week or longer.) | Y | N |
| 5. Has the patient been assessed for clinical risks of opioid abuse and/or addiction by one of the following tools, or another assessment tool for opioid abuse: CAGE questionnaire, Cyr-Wartman Screen, Skinner Trauma Screen, Screener and Opioid Assessment for Patients with Pain (SOAPP)? | Y | N |



**Arkansas
BlueCross BlueShield**
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Comments:

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

Prescriber (Or Authorized) Signature and Date