Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Acetaminophen-caffeine-dihydrocodeine, Nucynta®, Oxaydo®, Oxymorphone, Trezix®
Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the requested drug below:

❑ Acetaminophen-caffeine-dihydrocodeine ❑ Oxaydo ❑ Trezix
❑ Nucynta ❑ Oxymorphone

Select the diagnosis below:

❑ Acute pain
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient had a trial of three (3) opioids in attempts to treat the patient's acute pain condition? ❑ **Yes** ❑ **No**
If **yes**, please document the date, drug, dose and frequency below:

Date	Drug	Dose & Frequency

Has the provider checked information on this patient in the state's Prescription Monitoring Program (PMP) database within the last 90 days? ❑ **Yes** ❑ **No**
If **yes**, please document date PMP database was checked: _____

Quantity limit requests:

What is the quantity requested per DAY? _____
Does the patient have a diagnosis of pain? ❑ **Yes** ❑ **No**
If **yes**, is this cancer pain? ❑ **Yes** ❑ **No**
Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**
If **yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).
*** Please note: Chart documentation of the above is required to be submitted along with this fax*

_____

_____

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Acetaminophen-caffeine-dihydrocodeine, Nucynta®, Oxaydo®, Oxymorphone, Trezix®
Prior Authorization Request Form (Page 2 of 2)

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****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.