Wellpoint

Oxycodone Extended-Release Agents Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	2. Physician information
Patient name:	Prescribing physician:
Patient ID #:	Physician address:
Patient DOB:	Physician phone #:
Date of Rx:	Physician fax #:
Patient phone #:	Physician specialty:
Patient email address:	Physician DEA:
	Physician NPI #:
	Physician email address:

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
Oxycontin	________________	__________________	Specify: _____________

7. Diagnosis: ____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

The following questions are required for all requests:

☐ Yes ☐ No Does the patient have a diagnosis of malignant cancer in the last 730 days?
☐ Yes ☐ No Does the patient have a history of an antineoplastic agent in the last 365 days?
☐ Yes ☐ No Does the patient have a diagnosis of chronic nonmalignant pain (CNMP) in the last 365 days?

The following questions are required for requests for strengths 60 mg and higher:

☐ Yes ☐ No Does the patient have less than 14 days of opioid therapy in the last 30 days?
☐ Yes ☐ No Has the patient tried other pain management therapies?
☐ Yes ☐ No Has the prescriber provided medical justification for the use of a higher strength?

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.
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☐ Yes ☐ No Does the patient have a pain management agreement with the prescriber?

☐ Yes ☐ No Is the requested quantity less than or equal to three tablets per day?

☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.

☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class.

☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the Texas Medicaid Preferred Drug List, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs**

9. Physician signature

______________________________ ______________________

Prescriber or authorized signature Date

PA of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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