



**OXYCONTIN QUANTITY
PRIOR AUTHORIZATION REQUEST
PHYSICIAN FAX FORM**

Only the prescriber may complete this form.

The following documentation is **REQUIRED** for prior authorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Kansas Web site at **www.bcbsks.com**.

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Phone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip:	Phone #:	Secure Fax #:		

PRIOR AUTHORIZATION INFORMATION

OXYCONTIN Strength _____ Quantity requested _____ Dosing Schedule _____
1. Patient's diagnosis to be treated with requested medication _____
2. Has the patient tried and failed an every 12 hours dosing schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the patient used an immediate-release analgesic between doses of OxyContin to manage break-through pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is a dose schedule of less than every 12 hours considered the most beneficial option for controlling pain in the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Can the dosage prescribed be accomplished with a lesser quantity of tablets? (e.g., one 20 mg tablet instead of two 10 mg tablets)..... <input type="checkbox"/> Yes <input type="checkbox"/> No

Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 1305 Corporate Center Drive Eagan, Minnesota 55121 TOLL FREE Fax: 877.480.8130 Phone: 866.469.5660	CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 866.469.5660, and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.
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