



**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
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130

Phone: 866.469.5660

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