

Pharmacy Medical Necessity Form

Last Reviewed: Nov. 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Oxycodone SR Tablets and Oxycontin® Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- Oxycodone SR 10 mg 20 mg 40 mg 80 mg
 Oxycontin CR 10 mg 15 mg 20 mg 30 mg 40 mg 60 mg 80 mg

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of Oxycodone/Oxycontin requires:

- Diagnosis of moderate to high chronic pain of more than 90 days duration
- Documented therapeutic trial of all of the following: MS Contin, Methadone, and Fentanyl
- Prescriber must be a contracted provider or pre-approved by Priority Health to see our members
- Prescribing of this medication is limited to a single individual, or single practice if Priority Health Contracts with other prescribers in the practice
- A signed copy of a pain management contract that contains language acceptable to Priority Health must be attached to this request
- Recent progress notes (dated within the last 60-90 days) that clearly list: diagnosis, patient perceived pain level, provider assessment of therapy, plan for continued therapy (drug, dose, dosing interval, quantity) must be attached to this request

Please Complete the Following Information:

Diagnosis:

- Moderate to high chronic pain of more than 90 days duration
 Other: _____ Please provide rationale for use: _____

Patient has had a therapeutic trial and clinical failure with **all** of the following:

- Yes
 MS Contin Date of Trial: _____ Result: _____
 Methadone Date of Trial: _____ Result: _____
 Fentanyl Date of Trial: _____ Result: _____
 No – Rationale for use: _____

Prescriber is a contracted participating provider **or** pre-approved by Priority Health to see our members:

Yes

No – Rationale for use: _____

Prescribing of this medication is limited to a single individual or single practice if Priority Health Contracts with other prescribers in the practice:

Yes

No – Rationale for use: _____

Unknown

A signed copy of a pain management contract that contains language acceptable to Priority Health is attached to this request (must be signed by both the patient and prescriber):

Yes

No – Rationale for use: _____

Recent progress notes (dated within the last 60-90 days) that clearly list: diagnosis, patient perceived pain level, provider assessment of therapy, plan for continued therapy (drug, dose, dosing interval, quantity) are attached to this request:

Yes

No – Rationale for use: _____

Duration of Therapy: May be granted for up to 90 days

***** All fields must be complete and legible for Prior Authorization Review*****

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX