# Oxycontin (oxycodone ER) Prior Approval Request

## Section A: All Forms of Oxycodone

1. Will the patient be using oxycodone concurrently with methadone (Dolophine) or a buprenorphine medication such as Suboxone for opioid addiction? □ Yes (please select buprenorphine or methadone and answer questions a & b below) □ No

□ Buprenorphine medication for addiction: Do you agree the patient will be tapered off of the opioid within 30 days? □ Yes* □ No *If YES, please specify what medication(s), strength and quantity will be needed for 30 day taper: ____________________________

□ Methadone: Do you agree the patient will be tapered off of the methadone or the requested opioid within 30 days? □ Yes* □ No *If YES, please select taper methadone or taper opioid below:

□ Taper methodone: Please specify strength and quantity that will be needed for the 30 day taper: ____________________________

□ Taper opioid: Please specify what medication(s), strength and quantity that will be needed for 30 day taper: ____________________________

a. Has the patient had a recent injury, accident or surgery that requires the addition of an opioid to their therapy? □ Yes □ No

b. Will the patient be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential of diversion to others? □ Yes □ No

2. Is the prescribing physician a board certified oncologist? □ Yes □ No

3. Does the prescriber agree to assess the patient after 3 months of therapy for the benefits of pain control (i.e. care plan, signs of abuse, severity of pain)? □ Yes □ No

4. Will the patient be assessed for serotonin syndrome? □ Yes □ No

5. Will the patient be concurrently using alprazolam (Xanax), diazepam (Valium), or lorazepam (Ativan)? □ Yes □ No

6. Will the patient be concurrently using clonazepam (Klonopin), oxazepam (Serax), chlordiazepoxide (Librium), or clorazepate dipotassium (Tranxene)? □ Yes □ No

## Section B: Oxycodone IR / Solution

1. Dosing Directions: Total tabs/caps/ml requested: _________ per 90 days

2. Is the patient experiencing moderate to severe pain? □ Yes □ No

3. Will oxycodone IR / solution be used with other immediate release opioid analgesic(s)? □ Yes □ No

4. Has the patient been on oxycodone IR / solution therapy continuously for the last 4 months? □ Yes □ No* *If NO, have alternative treatment options, including non-opioid analgesics, been ineffective, not tolerated or inadequate for controlling the pain? □ Yes □ No

## Section C: Oxycontin / Xtampza (oxycodone ER)

1. Dosing Directions: Total quantity requested: _________ per 90 days

2. Has the patient received oxycodone ER within the last 180 days? □ Yes □ No* *If NO, has the patient been on a previous immediate-release opioid therapy for at least 10 days in the last 90 days? □ Yes □ No

3. Is the patient experiencing pain that is severe enough to require daily, around-the-clock long term opioid treatment? □ Yes □ No

4. Have alternative treatment options, including non-opioid analgesics and opioid immediate release analgesics, been ineffective, not tolerated or inadequate for controlling the pain? □ Yes □ No

5. Will the patient be taking any other long acting (extended release) opioid analgesic(s) while on oxycodone ER therapy? □ Yes □ No

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**Additional Information Required:**
- Process your claim for prescription drugs. Complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. Incomplete and illegible forms will be returned to the patient.
- If NO to the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. If YES to any of the above, please select the appropriate option below.

**Dosing Directions:**
- Oxycodone Solution 5mg/5ml (1mg/ml)
- Oxycodone Solution 20mg/5ml & (10mg/0.5ml)

**Physician Signature:**
Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Electronically Online (ePA)</td>
<td>Now you can get responses to drug prior authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA.</td>
</tr>
<tr>
<td>Phone</td>
<td>The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.</td>
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<tr>
<td>Fax</td>
<td>Fax the attached form to (877)-378-4727 Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the PA request cannot be processed. Please only fax the completed form once as duplicate submissions may delay processing times.</td>
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The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.