Prior Authorization Form

Oxycontin Post Limit

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Oxycontin Post Limit.

Drug Name
(specify drug) ______________________________

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: ______________________________
Patient ID: ______________________________
Patient Group No.: ______________________________
Patient DOB: ______________________________
Patient Phone:

Prescribing Physician
Physician Name: ______________________________
Physician Phone: ______________________________
Physician Fax: ______________________________
Physician Address: ______________________________
City, State, Zip: ______________________________

Diagnosis: ______________________________ **ICD Code:** ______________________________

Comments: ______________________________

Please circle the appropriate answer for each question.	
1. Does the patient have significant respiratory depression OR known or suspected paralytic ileus?	Y N
2. Is the requested drug being prescribed for pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate?	Y N
3. Can the patient safely take the requested dose based on their current opioid use history?	Y N
4. Has the patient been evaluated and will be monitored regularly for the development of addiction, abuse, or misuse of the requested drug?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date