PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Oxycontin® (Oxycodone HCl)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	**Physician Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. Does the patient have a diagnosis of chronic pain due to: Cancer related pain Sickle Cell Crisis HIV related neuropathy Other
Q2. If other, please provide the diagnosis below.
Q3. What is the requested dosing frequency? Once daily Twice daily Three times daily
Q4. Does the patient have a documented intolerance to sustained release morphine sulfate, fentanyl, or Methadone? Yes No

Physician Signature **Date**

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