



**OXYCODONE CR  
PA FORM**

<b>Fax Completed Form to: 866-254-0761 For questions regarding this Prior authorization, call 866-773-0695</b>
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Prior Authorization Vendor for ND Medicaid
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**\*Note: The PA may be approved if all of the following criteria are met.**

- Patient has a chronic pain indication (includes cancer).
- Patient has taken an immediate release narcotic for the past 90 days or is switching from another sustained release opioid analgesic.

**Part I: TO BE COMPLETED BY PRESCRIBER**

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Prescriber Name					
Prescriber Medicaid Provider Number			Telephone Number		Fax Number
Address		City		State	Zip Code
<b>Requested Drug:</b> <input type="checkbox"/> OXYCODONE CR	<b>DOSAGE:</b>		<b>Diagnosis for this request:</b>		
<b>QUALIFICATIONS FOR COVERAGE:</b> <input type="checkbox"/> CHRONIC MALIGNANT PAIN INDICATION <input type="checkbox"/> CHRONIC NON-MALIGNANT PAIN INDICATION			<b>LIST IMMEDIATE RELEASE MEDICATION TAKEN:</b>		
<b>LIST OTHER SUSTAINED RELEASE OPIOID ANALGESIC PATIENT IS SWITCHING FROM:</b>					
<input type="checkbox"/> <i>I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.</i>					
Prescriber Signature				Date	

**Part II: TO BE COMPLETED BY PHARMACY**

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #		

**Part III: FOR OFFICIAL USE ONLY**

Date Received				Initials:	
Approved - Effective dates of PA: From:     /     / To:     /     /				Approved by:	
Denied: (Reasons)					