BlueCross BlueShield Federal Employee Program

OXYCODONE IR
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Member Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Cardholder Name:			Specialty:	NPI:	
Member Name:			Office Phone:		
Date of Birth:	Sex: Male Female		Office Fax:		
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Cardholder ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select prescribed form and provide quantity:

❑ **Oxaydo 5mg tabs**	**qty _____ per 90 days**	❑ **Oxaydo 7.5mg tabs**	**qty _____ per 90 days**
❑ **Oxycodone 5mg caps**	**qty _____ per 90 days**	❑ **Oxycodone 5mg tabs**	**qty _____ per 90 days**
❑ **Oxycodone 10mg tabs**	**qty _____ per 90 days**	❑ **Oxycodone 15mg tabs**	**qty _____ per 90 days**
❑ **Oxycodone 20mg tabs**	**qty _____ per 90 days**	❑ **Oxycodone 30mg tabs**	**qty _____ per 90 days**
❑ **Oxycodone solution 1mg/ml**	**qty _____ per 90 days**	❑ **Oxycodone solution 20mg/ml**	**qty _____ per 90 days**
❑ **Roxybond 5mg tabs**	**qty _____ per 90 days**	❑ **Roxybond 15mg tabs**	**qty _____ per 90 days**
❑ **Roxybond 30mg tabs**	**qty _____ per 90 days**		

1. Will the patient be using the medication concurrently with methadone (Dolophine) or a buprenorphine medication such as Suboxone for opioid addiction? ❑Yes* ***(*If YES, please select buprenorphine or methadone and answer question a below)*** ❑No
   - ❑ **Buprenorphine:** 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 methadone**: 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 or has the patient been started on an opioid addiction medication? ❑Yes ❑No
2. Is the **prescribing physician** a board certified oncologist? ❑Yes ❑No
3. What level of pain is the patient being treated for? ❑Mild ❑Moderate ❑Moderate to severe ❑Severe
4. Is the patient being treated for acute or chronic pain? ***Please select answer below:***
   - ❑ **Acute**: Does the prescriber agree to discontinue therapy after 30 days? ❑Yes ❑No
   - ❑ **Chronic**: Does the physician agree to assess the benefits of pain control, for example, by implementing a Care Plan, monitoring for signs of misuse/abuse using standard lab screening (i.e. urine, blood) and evaluating severity of pain after 3 months of therapy? ❑Yes ❑No
5. Does the physician agree to assess the patient for serotonin syndrome? ❑Yes ❑No
6. Will the patient be using Oxycodone IR/Oxaydo/Roxybond in combination with alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), or lorazepam (Ativan)? ❑Yes ❑No
7. Will the patient be using Oxycodone IR/Oxaydo/Roxybond in combination with oxazepam (Serax), chlordiazepoxide (Librium), or clorazepate dipotassium (Tranxene)? ❑Yes ❑No
8. Has the patient been on Oxycodone IR/Oxaydo/Roxybond continuously for the last **4 months**? ❑Yes ❑No*
   If NO, have alternative treatments, including non-opioid analgesics, been ineffective, not tolerated or inadequate for controlling the pain? ❑Yes ❑No
9. Will the patient also be taking an extended release (ER) opioid? ❑Yes* ❑No
   If YES, please specify strength and quantity per 90 days: _____
10. Will the patient be taking this medication with another immediate release (IR) opioid analgesic(s)? ❑Yes* ❑No
    If YES, please specify: _____

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.

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Message:

Attached is a Prior Authorization request form.

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

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	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.**
Phone (4-5 **minutes** for response)	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.
Fax (3-5 **days** for response)	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.***

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