



FLORIDA MEDICAID PRIOR AUTHORIZATION

Oxycontin® (oxycodone ER)

Maximum length of approval = 3 months

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Pharmacy Name

Grid for Pharmacy Name

Pharmacy Medicaid Provider #

Grid for Pharmacy Medicaid Provider #

Pharmacy Phone Number

Grid for Pharmacy Phone Number

Pharmacy Fax Number

Grid for Pharmacy Fax Number

- 1. Recipient's diagnosis relating to the reasons for prescribing OxyContin® at this time?
2. Strength requested: \_\_\_\_\_ Daily Dosage: \_\_\_\_\_
3. Briefly describe the trial and failure of the preferred long-acting narcotic, Embeda (within the past 90 days).
(Legible copies of progress notes describing these events are required, please attach.)

Large empty box for notes or attachments

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs.

The provider must retain copies of all documentation for five years.

Mail or Fax Information to: Magellan Medicaid Administration, Inc. Prior Authorization P. O. Box 7082 Tallahassee, FL 32314-7082 Phone: 877-553-7481 Fax: 877-614-1078

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