# QUEST Integration Oxycodone CR (OxyContin®)
## Drug Coverage Request Form

Pharmacy Services Fax #: 973-6327, Toll-Free Fax (877)-316-6376

| MEMBER INFORMATION | | |
|---|---|---|
| Name: | Member ID #: | D.O.B.: |

| PROVIDER INFORMATION | | |
|---|---|---|
| Prescribing Provider Name: | Specialty: | |
| Office Contact Person: | Phone #: | Fax #: |

## Reason for Request & Requirements for Determination

☐ Standard (14 Calendar Days)

☐ Expedited * (3 Business Days) Reason: _____

*** Expedited review is reserved for medically necessary of life threatening requests. Provide reason for expedited review above**

## INDICATE or PROVIDE

Oxycodone CR/OxyContin® **Strength:** ☐ 10mg ☐ 15mg ☐ 20mg ☐ 30mg ☐ 40mg ☐ 60mg ☐ 80mg

☐ **Directions:** _____ **Quantity:** _____ **Add Fills:** _____

☐ **Diagnosis*:** _____ ICD-10: _____

**** If diagnosis indicates cancer pain, stop here - no other information is required.***

☐ Diagnosis of moderate to high chronic pain of more than 90 days duration.

☐ Documented therapeutic trail of two (2) or more of the following formulary extended release narcotics:

- ☐ morphine sulfate ER: Date: _____ Result: _____
- ☐ methadone: Date: _____ Result: _____
- ☐ fentanyl: Date: _____ Result: _____

☐ A Pain Management Agreement signed within the last year submitted with this request or on file with AlohaCare.

☐ **Recent progress notes (dated within the last 60-90 days) that clearly list diagnosis, patient perceived pain level, provider assessment of therapy, and plan for continued therapy - required submission with this request.**

☐ Consult notes from any provider that has seen or treated member for above diagnosis (i.e. physical therapy, neurologist, physical therapy, neurologist, physiatrist, surgeon, etc.)

☐ Pertinent imaging results.

☐ History of Behavioral Health and/or Substance Abuse issues.

☐ Other: _____

Provider Signature: _____ Date: _____

## FOR ALOHACARE USE ONLY:

☐ **APPROVED** Date Approved: _____ Through: _____ # of Refills: _____

☐ **NOT APPROVED**** Date Denied: _____ Time: _____ Denial Reason**: _____

_____

_____

_____

Reviewer: _____ Date: _____