STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035

(This and other PA forms are posted on www.ctdssmap.com and can be accessed by clicking on the pharmacy icon)

CT Medical Assistance Program
Opioid Prior Authorization (PA) Request Form

To Be Completed By Prescriber

Prescriber Information	**Patient Information**
Prescriber's NPI:	Patient Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone #: ( )	Patient DOB: / /
Fax #: ( )	Primary ICD Diagnosis Code:
Prescription Information	
Drug Requested:	Dose/frequency:
□ New therapy □ Continuation	Expected Duration:

This form must be completed by the prescribing provider. If the form is missing information, the PA will not be processed.

Clinical Information

Is the patient 12 years of age or older?	□ Yes	□ No
Does the patient have a diagnosis of cancer and/or sickle cell disease?	□ Yes	□ No*
Is the patient under the care of an Oncologist or pain specialist who is experienced in the use of Schedule II opioids to treat cancer pain?	□ Yes	□ No*
Is the patient free from all of the following contraindications: hypersensitivity to opiates, hypoxia/hypercarbia, severe asthma or chronic obstructive pulmonary disease, or paralytic ileus?	□ Yes	□ No*
The patient needs an ongoing, continuous course of therapy for Short Acting Opioids or an ongoing, continuous course of therapy and not on an as needed basis for Long Acting Opioids.	□ Yes	□ No

If you answered 'YES' to all of the questions above, please fax the completed form to the DXC Technology Pharmacy PA Assistance Center at the number above for processing.

*** If you answered 'NO' to any of the questions above, a Letter of Medical Necessity (LMN) must be reviewed by the Medical Director for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat § 17b-259b(a)) of a Short Acting Opioid or Long Acting Opioid for this patient. Submit request, via fax, to 860-424-4822.**

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1-13 and 4a-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the client is under my clinic's/practice's ongoing care. I certify that I am a practitioner and hold a current, unrestricted license that allows me to prescribe medication and that I am enrolled in the CT Medical Assistance Program.

Prescriber Signature: _____ **Date:** _____