#### 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 <u>www.ctdssmap.com</u> and can be accessed by clicking on the pharmacy icon)

### CT Medical Assistance Program Long Acting Sustained Release Opioid Prior Authorization (PA) Request Form

# **To Be Completed By Prescriber**

<b>Prescriber Information</b>	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.

# **<u>Clinical Information</u>**

Is the patient 12 years of age or older?	□ Yes	□ No
Does the patient have a diagnosis of cancer?		□ 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?		□ 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?		□ No*
The patient needs an ongoing, continuous course of therapy and not on an as needed basis.		□ No

## <u>If you answered 'YES' to all of the questions above, please fax the completed form to the DXC</u> <u>Technology Pharmacy PA\_Assistance Center at the number above for processing.</u>

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

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:

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