

Blue Cross and Blue Shield of Vermont and The Vermont Health Plan Prior Approval Form Quantity Limit Authorization

Oxycontin
BCBSVT and TVHP Fax # (888)255-1006

Please complete information, sign, and date. When criteria are met BCBSVT/TVHP will authorize coverage of quantities exceeding standards. Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____

BCBSVT/TVHP Member ID#: _____ Date of birth: _____

Provider Name: _____ Provider Phone number: _____

Provider Fax number: _____ PCP Name: _____

Quantity requested _____ for a 30-day supply

INDICATIONS FOR USE	YES	NO
1. Does the patient have the diagnosis of ,moderate to severe pain?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the patient currently on chronic daily opioid therapy?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the patient taking Oxycontin more often than every 12 hours?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the patient being prescribed Oxycontin for around the clock pain relief?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the patient opioid tolerant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is patient taking oxycodone PRN for breakthrough pain?	<input type="checkbox"/>	<input type="checkbox"/>
7. Did patient have a dosage adjustment since the previous prescription was filled?	<input type="checkbox"/>	<input type="checkbox"/>

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

