

## ~ LONG ACTING NARCOTICS ~

### Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of long acting narcotics. These limits and criteria are based on concerns about safety and the potential for abuse and diversion. In order for beneficiaries to receive coverage for this drug, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

**Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549**

**Prescribing physician:**

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

**Beneficiary:**

Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Contact Person at Office: \_\_\_\_\_

Drug Requested:

 Please indicate: Brand Name  or Generic Equivalent 

Dose /Frequency and Length of Therapy:

Diagnosis or Indication for Use::

Has the member previously tried any of the following preferred medications?

<i>Check all that apply:</i>	<i>Response, check all that apply:</i>		
Fentanyl Patches	side-effect	non-response	allergy
Methadone	side-effect	non-response	allergy
Morphine ER	side-effect	non-response	allergy

Is this an initial request or a subsequent request?      Initial      Subsequent

Prescriber comments:

**Prescriber Signature:** \_\_\_\_\_

**Date of this request:** \_\_\_\_\_