PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Hydrocodone-Acetaminophen Products
Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to moderately severe pain
❑ Other diagnosis:_____ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Hycet
❑ Hydrocodone-acetaminophen (APAP) 300mg
❑ Hydrocodone-APAP 325mg
❑ Hydrocodone-ibuprofen 5-200mg
❑ Hydrocodone-ibuprofen 7.5-200mg
❑ Hydrocodone-ibuprofen 10-200mg
❑ Ibudone
❑ Lorcet
❑ Lorcet HD
❑ Lorcet Plus
❑ Norco
❑ Oxycodone-APAP
❑ Oxycodone-aspirin
❑ Oxycodone-ibuprofen
❑ Primlev
❑ Vicodin
❑ Vicodin ES
❑ Vicodin HP
❑ Zamicet

Quantity limit requests:

What is the quantity requested per DAY? _____

Does the patient's diagnosis include malignant (cancer) pain? ❑ **Yes** ❑ **No**
Was the medication prescribed by a pain specialist or by pain management consultation? ❑ **Yes** ❑ **No**

Select all of the following that have been maintained and documented in chart notes:

❑ A description of the nature and intensity of the pain
❑ An appropriate patient medical history and physical examination
❑ An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
❑ Appropriate dose escalation
❑ Ongoing, periodic review of the course of opioid therapy
❑ Verification that the risks and benefits of the use of the requested drug have been discussed with the patient, significant other(s), and/or guardian

Chart documentation:

Will chart documentation be submitted to *ProAct*® with this form, confirming the above information? ❑ **Yes** ❑ **No**
***Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.*

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	