

# MAGELLAN COMPLETE CARE

Prior Authorization

**Oxycodone ER (Oxycontin®)**

Maximum Length of Approval = Six Months

**Note:** Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

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Date of Birth (MM/DD/YYYY)

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Recipient's Full Name

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Prescriber's Full Name

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Prescriber License # (ME, OS, ARNP, PA)

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Prescriber Phone Number

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Prescriber Fax Number

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Pharmacy Name

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Pharmacy Medicaid Provider #

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Pharmacy Phone Number

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Pharmacy Fax Number

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1. Recipient's diagnosis relating to the reasons for prescribing OxyContin® at this time? \_\_\_\_\_

2. Strength Requested: \_\_\_\_\_ Daily Dose: \_\_\_\_\_

3. Briefly describe the clinical course of the two different long-acting narcotics that have failed or were not tolerated (within the past 90 days) (Legible copies of progress notes describing these events are required, please attach.)

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PRESCRIBER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**REQUIRED FOR REVIEW:** Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Fax or mail completed forms to:

Magellan Complete Care  
 c/o Magellan Pharmacy Solutions  
 11013 West Broad Street, Suite 500  
 Glen Allen, VA 23060

Phone: 1-800-327-8613  
 TTY: 1-800-424-1694  
 Fax: 1-800-424-7982

