Reset Form Print Form

FLORIDA MEDICAID

Prior Authorization

Oxycodone ER (Oxycontin®)

Beneficiary's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Beneficiary's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, RN)

Prescriber Phone Number -

Prescriber Fax Number -

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number -

Pharmacy Fax Number -

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

   _____

2. Strength requested: _____ Daily Dosage: _____
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.)

Prescriber's Signature: _____ DATE:

Please attach a copy of the original prescription.

Additional documentation such as medical records may be requested. The provider must retain copies of all documentation for five years.

Fax or mail completed forms to:
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: (877) 553-7481
Fax: (877) 614-1078

For AHCA Use Only

DATE: _____ **NOTIFIED:** _____

APPROVED: _____ **START DATE:** _____ **EXPIRATION DATE:** _____

DENIED: _____ **REASON:** _____