



**Texas Medicaid/CHIP Vendor Drug Program**  
**Texas Standard Prior Authorization Form Addendum**  
**Oxycontin® (oxycodone ER)**

In addition to the *Texas Standard Prior Authorization Request Form for Prescription Drug Benefits*, please complete the information below. This information is essential to processing the prior authorization for the selected drug. Incomplete forms or failure to submit this addendum may cause delays in patient care and/or prior authorization denial. Please fax the completed Standard Prior Authorization Form and Addendum to (866) 469-8590 for Fee-For-Service patients. If the patient is enrolled in managed care, please contact the appropriate health plan for forms and instructions.

**SECTION I — PATIENT INFORMATION**

NAME:	MEDICAID ID #:	DOB:
-------	----------------	------

**SECTION II — PRESCRIBER INFORMATION**

NAME:	NPI#:	PHONE:
-------	-------	--------

**SECTION III — MEDICATION INFORMATION**

1. Does the patient have a diagnosis of malignant cancer or chronic non-malignant pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Has the patient tried non-prescription pain management therapies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. If the prescribed strength exceeds 40 mg, in the space below, please explain why a higher strength is necessary.		
4. If the prescribed strength exceeds 40 mg, does the patient have a pain management agreement with the prescriber?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**SECTION IV — REVIEW**

Expedited/Urgent Review Requested  
 By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

\_\_\_\_\_  
 Signature of Prescriber or Prescriber's Designee

\_\_\_\_\_  
 Date