



**Kansas Medical Assistance Program**  
P O Box 3571  
Topeka, KS 66601-3571  
Provider 1-800-933-6593  
Beneficiary 1-800-766-9012

**Long Acting Opioid Products  
Prior Authorization Request Form**

**Beneficiary Name:** \_\_\_\_\_

**Beneficiary Medicaid ID #:** \_\_\_\_\_ **Date Of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_

**Pharmacy Medicaid ID#:** \_\_\_\_\_ **Pharmacy NPI#:** \_\_\_\_\_

**Phone number:** (\_\_\_\_) \_\_\_\_\_ **Fax number:** (\_\_\_\_) \_\_\_\_\_

**NDC Requesting:** \_\_\_\_\_

**Prescribing Physician's Name:** \_\_\_\_\_

**Physician Medicaid ID#:** \_\_\_\_\_ **Physician NPI#:** \_\_\_\_\_

**Phone number:** (\_\_\_\_) \_\_\_\_\_ **Fax number:** (\_\_\_\_) \_\_\_\_\_

Please provide the diagnosis for which the therapy is being prescribed (no dx codes) \_\_\_\_\_

Is the beneficiary's dose being titrated over the past 3 months? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain the changes in the regime over the past 3 months \_\_\_\_\_

Is the beneficiary terminally ill? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, does the beneficiary have a signed opioid treatment agreement with the prescriber? Yes \_\_\_ No \_\_\_

**Signature of Physician or Designee:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.  
This form will be returned unprocessed if it is not completed in its entirety.**