



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

**Meperidine, Hydromorphone, Oxycodone SR
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 unable to take NSAIDS due to adverse effects or contraindications? Yes _____ No _____

Is the beneficiary unable to take conventional therapy due to adverse effects or contraindications? Yes ___ No ___

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.**