



**Kansas Medical Assistance Program**

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

**Prior Authorization for Non-Preferred Long-Acting Opioids**

Preferred	Non-Preferred-Prior Authorization Required
Duragesic® (fentanyl) Embeda® (morphine/naltrexone) MS Contin® (morphine sulfate ER) OxyContin® (oxycodone SR) Ultram ER® (tramadol ER)	Avinza® (morphine sulfate ER) Belbuca® (buprenorphine) Butrans® (buprenorphine) ConZip® (tramadol) Exalgo® (hydromorphone HCl ER) Hysingla ER® (hydrocodone ER) Kadian® (morphine sulfate ER) Nucynta ER® (tapentadol) Opana ER® (oxymorphone) Ryzolt® (tramadol ER) Zohydro ER® (hydrocodone bitartrate ER)

**Beneficiary Information**

Name: \_\_\_\_\_  
Medicaid ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Pharmacy Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Requested Drug: \_\_\_\_\_ NDC: \_\_\_\_\_

**Prescriber Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Please check the appropriate box and provide the required information to receive the requested non-preferred drug.

- Patient has a medical intolerance to preferred drug.** Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: \_\_\_\_\_
- Patient has had an inadequate response to preferred drug.** Name of preferred agent patient tried: \_\_\_\_\_
- An appropriate formulation or indication is not available as a preferred drug.** Please specify which formulation or indication is needed and information supporting the need: \_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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