

Please note: All information below is required to process this request.

Fax to 1-844-403-1029 Mon-Sat: 7am to 7pm Central

Hydrocodone-acetaminophen (APAP) Products Prior Authorization Request Form (Page 1 of 2)

Member Information (required) Member Name: Insurance ID#: Date of Birth: Street Address: City: State: Zip:	Provider Name: NPI#: Office Phone: Office Fax: Office Street Address: City:	State:	Specialty: Zip Dosage Form:		
Insurance ID#: Date of Birth: Street Address:	NPI#: Office Phone: Office Fax: Office Street Address: City: Ormation (required) Strength:		Zip	p:	
Date of Birth: Street Address:	Office Phone: Office Fax: Office Street Address: City: Ormation (required) Strength:		Zip	p:	
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	Office Street Address: City: ormation (required) Strength:			p:	
City: State: 7in-	City: ormation (required) Strength:			p:	
5, Zipi	ormation (required) Strength:			p:	
Phone:	Strength:		Dosage Form:		
Medication Information (required)					
Medication Name:	Directions for Use:		Doougo i oiiiii		
☐ Check if requesting brand		Directions for Use:			
☐ Check if request is for continuation of therapy					
Clinical Information (required)					
Medication history: Has the patient had a history of a 60 day trial (in the past 90 day below? □ Yes □ No • Hydrocodone-APAP 5-325 • Hydrocodone-APAP 10-325 Clinical information: Does the patient have a diagnosis of cancer in the past 365 day Does the patient have a diagnosis of a terminal illness? □ Yest Does the patient have an illness associated with significant pair of the patient have an injury associated with significant pair of the patient have an injury associated with significant pair of the patient have an injury associated with significant pair of the patient have an injury associated with significant pair of the patient have an injury associated with significant pair of the patient have an injury associated with significant pair of the patient to the lowest effect of the patient to the patient	ys?	mia, etc)?			
Reauthorization: If this is a reauthorization request, answer the following: Is the prescriber maintaining the most conservative, effective tr If yes, please provide documentation:		No			



Hydrocodone-acetaminophen (APAP) Products Prior Authorization Request Form (Page 2 of 2) DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?						
Please note:	This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.					

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