

South Dakota Department of

Social Services

Ultram[®] ER (tramadol extended-release [ER]) Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)				
Member Name:			Provider Name:				
Insurance ID#:			NPI#: Specialty:				
Date of Birth:			Office Phone:				
Street Address:			Office Fax:				
City:	State:	Zip:	Office Street Address:				
Phone:			City:	State: Zip:		Zip:	
		Medication Info	ormation (required))			
Medication Name:			Strength:		Dosage Form:		
Check if requesting brand			Directions for Use:				
Check if request is for continuation of therapy							
		Clinical Infor	mation (required)				
Clinical information:							
Is the patient currently stable on tramadol ER tablet or Ultram ER? D Yes D No							
Has the patient failed a 30 day trial of immediate release tramadol in the last 120 days? D Yes D No							
Does the patient have a diagnosis of cancer in the past 365 days?							
Does the patient have a diagnosis of a terminal illness? D Yes D No							
Does the patient have an <u>illness</u> associated with significant pain (e.g., sickle cell anemia, etc)? U Yes U No							
Does the patient have an <u>injury</u> associated with significant pain?							
Have efforts been made to taper the patient to the lowest effective dose? Yes No							
Reauthorization:							
If this is a reauthorization request, answer the following: Is the prescriber maintaining the most conservative, effective treatment? U Yes U No							
If yes, please provide documentation:							
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to							

Please note:

this review?

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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