Butrans Patch Coverage Determination

Mail requests to: Coverage Determination & Exceptions
PO Box 20002 Nashville, TN 37202
Fax requests to: (866) 845-7267
Request by phone: (877) 813-5595

FOR PROVIDER USE ONLY

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Provider Address:

License Number:	**DEA Number:**	**NPI Number:**

Customer Name:

Customer Address:

Customer Phone:(H)	**(C)**
Customer ID:	**DOB:**

Rx	**Prescription Information**		
Drug:	**Dosage:**	**Frequency:**	**Quantity:**

□ **Brand**	□ **Generic**	□ **New Medication**	□ **Continuation (Provide Start Date)**	**Refills:**

List Diagnosis/ICD-10 code (s): ______________________

Select all formulary alternatives that the Customer has tried/failed, please include the duration of therapy (Start and End Dates):

Fentanyl Patch: ________ Morphine Sulfate ER tablets: ________
Oxymorphone ER: ________ Methadone: ________

List any adverse reaction, negative outcome, or intolerance Customer has experienced with above agents:

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Is the request for an inpatient that is awaiting discharge? Yes No

Plan requires a 30 day minimum trial and failure of at least 2 formulary alternatives.

☐ ***By Checking this box, I certify that I have reviewed the clinical information needed for approval, and have no further information to provide regarding this request.***

☐ ***Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum function.***

Provider Signature: **Date:**

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