

## Cough and Cold (Opiate Combination) – Arizona Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.  
Allow at least 24 hours for review.**

### Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:

Primary Insurance Information (if any):

**Is the requested medication:**  New or  Continuation of Therapy? If continuation, list start date: \_\_\_\_\_

**Is this patient currently hospitalized?**  Yes  No If recently discharged, list discharge date: \_\_\_\_\_

### Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
NPI #:	Phone:	Fax:	Specialty:

Office Contact Name / Fax attention to:

### Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:

Is this member pregnant?  Yes  No      If yes, what is this member's due date? \_\_\_\_\_

### Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

### Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
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**Clinical and Drug Specific Information**

**ALL REQUESTS:**

- Does the provider attest they are aware of the patient's current opioid therapy and MED dose and feels the treatment with the requested product is medically necessary?  Yes  No
- Has the patient had a history of failure, contraindication or intolerance to a trial of at least three preferred cough and cold products?  Yes  No  
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

**Requests for LESS THAN THE FDA APPROVED MINIMUM AGE:**

- Does the prescriber attest they are aware of FDA labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary?  Yes  No  
If yes, list rationale for use: \_\_\_\_\_
- Does the patient have a comorbid condition that may impact respiratory depression?  Yes  No  
(e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30)  
If yes, list comorbid condition: \_\_\_\_\_
- Has the patient tried and failed at least one non-opioid containing cough and cold remedy?  Yes  No  
If yes, List non-opioid containing cough and cold remedy / reason for d/c: \_\_\_\_\_

**Requests to EXCEED QUANTITY LIMIT:**

- Does the prescriber attest that a larger quantity is medically necessary?  Yes  No
- Is there a reason why a greater quantity of medication is required to treat the patient's condition?  Yes  No  
If yes, list reason: \_\_\_\_\_
- Is the requested dose within the FDA maximum dose per day, where an FDA maximum dose per day exists?  
 Yes  No

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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