USAble Administrators

Physician's Prior Authorization Questionnaire
Onsolis®

Patient: **ID#:** **DOB:**

Patient Address:

Onsolis® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the medical diagnosis? (*Please do not use codes.*) ______________________________

2. Is the patient opioid tolerant? ☐ Yes ☐ No

   If *yes*, what other pain medications has/is the patient taken/taking?______________________

   ____

3. What dose and quantity of Onsolis® is the patient being prescribed? ______________________

______________________________ ______________________________
Physician's Signature Date

______________________________ ______________ / ______________
Please **Print** Physician's Name & Specialty Phone Number Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx