



Physician's Prior Authorization
Questionnaire for MS Contin® 200mg

PATIENT'S NAME: ID#: DOB:

Patient Address:

Please complete the questions below to assist us in making a determination of this patient's eligibility for coverage for this therapy.

- 1. What is the diagnosis of the patient (Please do not use codes)?
2. What opiate is the patient currently taking? Name of Drug: Current Daily Dose: Duration: of therapy:
3. What dose of MS Contin 200mg is requested?
4. Has the patient ever exhibited dependence on opiate medications? Yes No
5. Has the patient exhibited drug seeking behavior in the past? Yes No

Physician's Signature Date
Please Print Name Fax Number
Please Print Physician's Specialty Phone Number

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

Sincerely, Pharmacy Programs
Forms are also available online at http://usableadmin.abcbs.net/providers/PharmacyForms.aspx