

**BRAND NAME MEDICATION  
SCHEDULE II ANALGESIC CONTROLLED  
SUBSTANCE**

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_

Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone#: \_\_\_\_\_ Ext. and options \_\_\_\_\_ Fax# \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

Requested medication \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**NOTE: Prior authorizations for brand name medications in this drug class require physician evaluated, charted documentation of an allergic reaction or adverse reaction. Patient complaints of lack of efficacy are not acceptable reasons for failure such as “Client said”, “client reports”, “doesn’t work” or “causes nausea.”**

**CRITERIA:** \_\_\_\_\_

**Documentation** from **progress notes** detailing patient’s allergic skin eruption or adverse reaction to (801) 536-0477

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

Telephone request from physician or pharmacy

