FAX completed form to
Change Healthcare
1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program
PRIOR AUTHORIZATION REQUEST FORM

Narcotic Request Form

PHONE:
(For questions or inquiries ONLY)
1-877-207-1126

Provider must fill in all information below. It must be legible, correct and complete or the form will be returned.

Client ID #: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Client's Full Name: _____ DOB: _____

Prescriber NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Pharmacy Name: _____ Phone: _____

Drug Name (List one drug per form)	**Strength**	**Dosage Instructions**	**Days Supply**	**Quantity**	**Refills**

Client's medical diagnosis: _____

1. **Does client currently have a diagnosis of cancer?** ☐ **Yes** ☐ **No**
   If yes, please note that prior authorization requests for each narcotic and benzodiazepine desired must be submitted.

2. **Is the client female and between the ages of 18-45?** ☐ **Yes** ☐ **No**
   ***The use of opioid analgesics during pregnancy has been associated with neonatal abstinence syndrome. If the client is female and between the ages of 18-45:

   - Has this client been counseled regarding the risks of becoming pregnant while receiving this medication, including the risk of neonatal abstinence syndrome? ☐ **Yes** ☐ **No**
   - Is this client currently utilizing a form of contraception? ☐ **Yes** ☐ **No**
   - Has access to contraceptive services been offered to this client? ☐ **Yes** ☐ **No**

3. **Has the Wyoming Prescription Drug Monitoring Program (WORx) been reviewed for this client?** ☐ Yes ☐ No
   If yes, most recent date accessed: _____
   ***To request a client's controlled substance profile, please refer to WORx at http://www.worxpdmp.com.

***** For information regarding which medications are preferred as well as dosing limits, please see the Preferred Drug List and the Dosage Limitation List, which can be found at www.wymedicaid.org.**

Prescriber Signature: _____ Date(s) of Submission: _____
**** Prescriber's original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.***