WASHTENAW HEALTH PLAN
REQUEST FOR PRIOR AUTHORIZATION
REQUIRED FOR DOSES ABOVE 60MG/DAY ONLY
(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

REQUESTING PHYSICIAN:

Name
Direct Phone #
Fax #:
Physician Specialty

MEMBER INFORMATION:

Name
WHP ID#
Date of Birth
Gender: _Female _ Male

_____
Name and title of person completing form (please print)

MEDICATION	STRENGTH	DOSES PER DAY	PROPOSED LENGTH OF THERAPY (up to 6 months)
MORPHINE SULFATE			

Indication/Diagnosis for requested medication _ Oncology-related pain. Describe: _____ _ Orthopedic Surgery Describe:_____ _Chronic Back Pain. Describe:_____ _Other: Describe:_____	Past medical history, allergies or other pertinent medical information, that necessitates the use of this medication:

Previous WHP formulary medications tried and failed for this condition (name and strength of medication)	Dates of treatment	Reason for failure (outcomes, lab values, adverse effects, etc.)
1.		
2.		

ADDITIONAL QUESTIONS

1. Has the patient been seen by any other provider for this condition? If YES, what was the provider's specialty?
2. Has this member signed a pain contract with the physician prescribing this medication?
3. Was a MAPPS done?
Other Supporting Information (use additional pages if necessary):

Fax Requests to: Ingham Health Plan Corporation, Fax: (517) 394-4549
For more information, phone: (866) 291-8691

COMMENTS: