



Please complete ALL information below and fax your request to 1-888-671-5285

ConZip® & Tramadol extended-release (ER) capsule Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)
Select the diagnosis below: <input type="checkbox"/> Moderate to moderately severe chronic pain <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Medication history: Has the patient had a trial and failure, contraindication, or intolerance to a tramadol-containing product [e.g., Ultram (tramadol), Ultracet (tramadol-acetaminophen)]? <input type="checkbox"/> Yes <input type="checkbox"/> No
Quantity limit requests: What is the quantity requested per DAY? _____ What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.