



Prior Authorization Form

Controlled Substance: Prior authorization/Quantity Limit/Duplicate Therapy

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [] Fentora® [] Opana® [] Magnacet® [] Actiq® [] Fentanyl Citrate [] Onsolis®
[] Opana ER® [] Nucynta® [] Other (specify) _____

Dose _____ *Quantity _____

Date: _____ Patient ID#: _____ DOB: _____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

1. PROVIDER SPECIALTY (specify all) _____

2. DIAGNOSIS FOR DRUG REQUESTED: _____

3. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names, drug dosage and dates)
[] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug name (dose and frequency), Duration of therapy (include dates), Currently prescribed (Yes/No). Contains 4 rows for medication history.

4. PATIENT HISTORY:

ACTIQ, FENTORA AND ONSOLIS ONLY:

a. Is the patient tolerant to current opioid therapy (at least 60mg of oral morphine/day or an equi-analgesic dose of another opioid)? [] Yes [] No [] N/A

b. Has the patient tried and failed an oral transbuccal fentanyl citrate (Actiq®)? [] Brand [] Generic Must specify Date and Duration in the Medication History [] Yes [] No [] N/A

RE-AUTHORIZATION REQUESTS ONLY:

c. Provide evidence to support efficacy associated with current regimen (eg. Pain scores, clinical response):

DUPLICATE THERAPY REQUESTS ONLY:

d. Does the patient have contraindication or intolerance to higher doses of a single opioid? [] Yes [] No [] N/A

If the request is for duplicate therapy, please provide rationale for a requested combination. Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

* Please refer to "Controlled Substances Quantity Limit-Effective 05/01/2009" policy for quantity limits