FUTURE SCRIPTS

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

# Nasal and Oral Fentanyl Products Prior Authorization Request Form (Page 1 of 2)

**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: |
|---|---|---|
| ❑ Check if **generic substitution** is acceptable<br>❑ Check if request is for **continuation of therapy** | Directions for Use: | |

## Clinical Information (required)

**For states, such as GA and AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:**

Will the requested medication be used for the treatment of a terminal condition or associated symptoms? ❑ **Yes** ❑ **No**

If "YES", please indicate the patient's estimated life expectancy:

❑ Less than 6 months ❑ Less than 24 months ❑ Less than ____ months (please specify)

**Select the diagnosis below:**

Does the patient have a diagnosis of cancer? ❑ **Yes** ❑ **No**

If **yes** to the above, is the requested medication being used to manage breakthrough pain due to cancer? ❑ **Yes** ❑ **No**

❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Select any of the following which the patient has at least a one week history of:**

❑ An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day)
❑ Fentanyl transdermal patch at doses greater than or equal to 25 µg/hour
❑ Morphine sulfate at doses of greater than or equal to 60 mg/day
❑ Oral oxymorphone at a dose of greater than or equal to 25 mg/day
❑ Oral hydromorphone at a dose of greater than or equal to 8 mg/day
❑ Oxycodone at a dose of greater than or equal to 30 mg/day

**Medication history:**

Does the patient have a history of failure or intolerance to generic fentanyl lozenge? ❑ **Yes** ❑ **No**

**Current treatment:**

Is the patient currently taking a long-acting opioid around the clock for cancer pain? ❑ **Yes** ❑ **No**

**Prescriber specialty:**

Is the requested medication prescribed by or in consultation with a hematologist, hospice care specialist, pain specialist, palliative care specialist, or oncologist? ❑ **Yes** ❑ **No**

# Nasal and Oral Fentanyl Products Prior Authorization Request Form (Page 2 of 2)

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**Quantity limit requests:**

What is the quantity being requested per DAY: _____

**Select all of the following that have been maintained and documented in chart notes:**

- ❑ A description of the nature and intensity of the pain
- ❑ An appropriate patient medical history and patient physical examination
- ❑ An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
- ❑ Appropriate dose escalation
- ❑ Ongoing, periodic review of the course of opioid therapy
- ❑ Verification that the risks and benefits of the use of the controlled substance have been discussed with the patient, significant other(s), and/or guardian

**Chart documentation:**

Will chart documentation be submitted to *FutureScripts*® with this form, confirming the above information? ❑ **Yes** ❑ **No**

***Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.*

**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.