P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Actiq®, Fentora™, Onsolis™, Abstral®, Lazanda®, and Subsys ™
(fentanyl: transmucosal citrate, buccal tablet, buccal soluble film, sublingual tablet, nasal spray and sublingual spray

Therapeutic use: Management of breakthrough cancer pain in opioid-tolerant patients

Quantity Limit:

- Initial dose of Actiq and Onsolis should be 200 mcg; initial dose of Fentora, Abstral, Lazanda and Subsys should be 100 mcg
- Patients should only be prescribed a total of six dosage units to begin. Only after all units are used should the dose be titrated up.

Authorization Period: 3 to 6 months

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | | / | | | | |

ICD-9 | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | | - | | | | | Fax# | | | | - | | | | |

Physician's signature_____ Date signed | | | / | | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Which medication is being requested? ❑ Actiq ❑ Fentora ❑ Onsolis ❑ Abstral ❑ Lazanda ❑ Subsys Quantity requested? _____		
2.	Is the prescribing physician an oncologist or pain specialist?	❑ Yes	❑ No
3.	Does the patient have an active diagnosis of cancer? **COVERAGE WILL NOT BE APPROVED FOR NON-CANCER PAIN.**	❑ Yes	❑ No
4.	For Fentora/Onsolis/Abstral/Lazanda/Subsys, has the member failed a trial of generic oral transmucosal fentanyl citrate (Actiq)?	❑ Yes	❑ No

Please list the opioids that have been tried in the table below.

Name of Opioid	Duration of Therapy
a.	
b.	
c.	
d.	

- Must have documented evidence of maintenance therapy with a long-acting opioid, e.g., Oxycontin, MS Contin, Oramorph SR, etc.
- Must have failed therapy with at least two short-acting opioids for breakthrough pain, e.g., Percocet, Lortab, Percodan, Roxicodone, OxylR, etc.

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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Last Updated: March 19, 2012