

PREAUTHORIZATION FORM

Actiq[®], Fentora[™], Onsolis[™], Abstral[®], and Lazanda[®]

(fentanyl: transmucosal citrate, buccal tablet, buccal soluble film, sublingual tablet and nasal 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 and Lazanda 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? <input type="checkbox"/> Actiq <input type="checkbox"/> Fentora <input type="checkbox"/> Onsolis <input type="checkbox"/> Abstral <input type="checkbox"/> Lazanda Quantity requested? _____		
2.	Is the prescribing physician an oncologist or pain specialist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Does the patient have an active diagnosis of cancer? COVERAGE WILL NOT BE APPROVED FOR NON-CANCER PAIN.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	For Fentora/Onsolis/Abstral/Lazanda, has the member failed a trial of generic oral transmucosal fentanyl citrate (Actiq)?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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, OxyIR, 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.