FAX Completed Form To
1-844-512-9004

Provider Help Desk
1-800-454-3730
https://providers.amerigroup.com

Request for Prior Authorization
FENTANYL, SHORT ACTING PRODUCTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for short acting fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. Short acting fentanyl products:

- **Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain.**
- **Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.**

PLEASE NOTE THERE IS A BLACK BOX WARNING FOR THIS PRODUCT

Non-Preferred

☐ Abstral ☐ Fentora ☐ Onsolis
☐ Actiq ☐ Lazanda ☐ Subsys

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

☐ **Breakthrough Cancer Pain (no malignancies)**
☐ **Breakthrough Cancer Pain (with malignancies)**
☐ **Other (specify):** _____

Prescriber Specialty:

☐ Oncologist
☐ Pain management specialist
☐ Other **(specify):** _____

Current opioid therapy: Drug Name _____ Strength _____

Dosage instructions _____ Opioid duration of therapy: _____ weeks/months/years **(circle)**

Additional relevant information: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.* ***CASE NUMBER:*** 1624864