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Fentanyl Agents (Abstral, Actiq, Duragesic, Fentora, Lazanda, and Subsys) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	**2. Physician information**
Patient name:	Prescribing physician:
Patient ID #:	Physician address:
Patient DOB:	Physician phone #:
Date of Rx:	Physician fax #:
Patient phone #:	Physician specialty:
Patient email address:	Physician DEA:
	Physician NPI #:
	Physician email address:

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
□ Abstral (fentanyl sublingual tablet) □ Actiq (oral transmucosal fentanyl) □ Duragesic (transdermal fentanyl) □ Fentora (buccal fentanyl) □ Lazanda (fentanyl nasal spray) □ Subsys (fentanyl sublingual spray)	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

For Abstral (fentanyl sublingual tablet), Lazanda (fentanyl nasal spray), or Subsys (fentanyl sublingual spray) requests, please answer the following questions:

☐ Yes ☐ No Does the patient have a diagnosis of malignancy in the last 730 days?
☐ Yes ☐ No Does the patient have a history of antineoplastic therapy in the last 365 days?
☐ Yes ☐ No Does the patient have a history for a long-acting opioid analgesic in the last 30 days?
☐ Yes ☐ No Does the patient have a history for MAOI therapy or use of a CYP3A4 inhibitor in the last 30 days?

☐ Yes ☐ No PLEASE NOTE: Is the total daily dose less than or equal to 3200mcg?

☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.

☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class.

☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For Actiq (oral transmucosal fentanyl) requests, please answer the following questions:

☐ Yes ☐ No Does the patient have a diagnosis of cancer or fibrotic lung disease in the last 730 days?

☐ Yes ☐ No Does the patient have a history of antineoplastic therapy in the last 365 days?

☐ Yes ☐ No Does the patient have a diagnosis of chronic non-malignant pain (CNMP) in the last 365 days?

☐ Yes ☐ No Does the patient have less than or equal to 7 days of opioid therapy in the last 30 days?

☐ Yes ☐ No Does the patient have a history of MAOI therapy or use of a strong/moderate CYP3A4 inhibitor in the last 30 days?

☐ Yes ☐ No Is the prescription for less than or equal to 4 units per day?

☐ Yes ☐ No **If the request is for Actiq (transmucosal fentanyl) greater than or equal to 400 mcg,** does the patient have history of Actiq (transmucosal fentanyl) therapy in the last 30 days with the dose greater than or equal to 200 mcg?

☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.

☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class.

☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For Duragesic (transdermal fentanyl) requests, please answer the following questions:

☐ Yes ☐ No Does the patient have a diagnosis of cancer or fibrotic lung disease in the last 730 days?

☐ Yes ☐ No Does the patient have a history of an antineoplastic agent in the last 365 days?

☐ Yes ☐ No Does the patient have less than or equal to 7 days of opioid therapy in the last 30 days?

☐ Yes ☐ No Does the patient have a diagnosis of chronic non-malignant pain (CNMP) in the last 365 days?

☐ Yes ☐ No Does the patient have a history of an inferring chronic nonmalignant pain (CNMP) nonopioid analgesic for less than or equal to 60 days out of the last 90 days?

☐ Yes ☐ No Is the requested dose less than or equal to 25mcg per hour?

☐ Yes ☐ No Does the patient have less than or equal to 14 days of opioid therapy in the last 30 days?

☐ Yes ☐ No Is the requested dose less than or equal to 600mcg per hour?

☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.

☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this

class.

☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For Fentora (buccal fentanyl) requests, please answer the following questions:

☐ Yes ☐ No Does the patient have a diagnosis of malignant cancer in the last 730 days?

☐ Yes ☐ No Does the patient have a history of an antineoplastic agent in the last 365 days?

☐ Yes ☐ No Does the patient have a history of opioid tolerance with defined oral morphine, transdermal fentanyl, oxycodone, hydromorphone **or** oxymorphone therapy in the last 30 days?

☐ Yes ☐ No Does the patient have a 12 days supply of opioid therapy in the last 14 days?

☐ Yes ☐ No Does the patient have a history of MAOI therapy or use of a CYP3A4 inhibitor in the last 30 days?

☐ Yes ☐ No Does the patient have a history of Fentora (buccal fentanyl) in the last 35 days?

☐ Yes ☐ No Does the patient have a history of Actiq 600, 800, 1200 or 1600 mcg in the last 35 days?

☐ Yes ☐ No Is this request for less than or equal to 4 units per day?

☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.

☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class.

☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs**.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

PA of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.