



Request for Prior Authorization
FENTANYL, SHORT ACTING PRODUCTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, 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.

- 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.