Prior Authorization Form

Duragesic

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-866-217-5644**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Duragesic.

Drug Name (select from list of drugs shown)

Duragesic (fentanyl) Fentanyl Transdermal Patch

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care? Y N

[If yes, then no further questions.]

2. Is the requested drug being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid? Y N

[Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]

3.	Can the patient safely take the requested dose based on their history of opioid use?	Y N
4.	Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder?	Y N
5.	Will the patient's pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date