Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Fentora

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 **1-888-836-0730**.
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 Fentora.

Drug Name (select from list of drugs shown)
Fentora (fentanyl buccal tablet)

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. This drug is indicated for the treatment of breakthrough CANCER related pain only. Does the patient have CANCER related pain? If yes, prescriber MUST submit chart notes or other documentation supporting a diagnosis of cancer related pain AND list type of cancer. Y N _____

[Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER RELATED DIAGNOSIS.]

2. Have chart notes or other documentation supporting a diagnosis of cancer related pain been submitted to CVS Health by fax? Y N

3. Is the drug being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain?	Y N
4. Can the patient safely take the requested dose based on their history of opioid use?	Y N
5. Which drug is being requested? Please check drug being requested.	
Abstral 600 mcg or 800 mcg (if checked, then go to 6)	☐
Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg (if checked, then go to 8)	☐
Actiq (all strengths) (if checked, then go to 8)	☐
Fentora (all strengths) (if checked, then go to 8)	☐
Onsolis 200 mcg, 400 mcg, 600 mcg (if checked, then go to 8)	☐
Onsolis 800 mcg or 1200 mcg (if checked, then go to 6)	☐
Lazanda 100 mcg (if checked, then go to 9)	☐
Lazanda 300 mcg or 400 mcg (if checked, then go to 7)	☐
Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg (if checked, then go to 8)	☐
Subsys 1200 mcg, 1600 mcg (if checked, then go to 10)	☐
6. Coverage is provided for up to 120 units per month of the following: A) Abstral 600 mcg, 800 mcg, B) Onsolis 800 mcg, 1200 mcg. Is MORE than this quantity needed to manage the patient's pain?	Y N
[No further questions.]	
7. Coverage is provided for up to 240 sprays per month (i.e., 30 bottles per month) of Lazanda 300 mcg, 400 mcg. Is MORE than this quantity needed to manage the patient's pain?	Y N
[No further questions.]	
8. Coverage is provided for up to 120 units per month of the following: A) Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg, B) Actiq (all strengths), C) Fentora (all strengths), D) Onsolis 200 mcg, 400 mcg, 600 mcg, E) Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg. If higher quantities are needed, additional questions are required. Is MORE than this quantity needed to manage the patient's pain?	Y N
[Note Subsys packaging: Supplied as 1 spray per blister for Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg.]	
[If no, then no further questions.]	

[If yes, then skip to question 11.]	
9. Coverage is provided for up to 240 sprays per month (i.e., 30 bottles per month) of Lazanda 100 mcg. If higher quantities are needed, additional questions are required. Is MORE than this quantity needed to manage the patient's pain?	Y N
[If no, then no further questions.]	
[If yes, then skip to question 11.]	
10. Coverage is provided for up to 240 sprays per month (i.e., 120 blisters per month) of Subsys 1200 mcg or 1600 mcg. If higher quantities are needed, additional questions are required. Is MORE than this quantity needed to manage the patient's pain?	Y N
[Note Subsys packaging: Supplied as 2 sprays per blister for Subsys 1200 mcg and 1600 mcg.]	
[If no, then no further questions.]	
11. Is the patient's dose of a concomitant long-acting analgesic being increased?	Y N
[If yes, then skip to question 13.]	
12. Are additional quantities of the requested drug needed for breakthrough pain because the dose of the patient's long-acting analgesic is unable to be increased?	Y N
[If no, then no further questions.]	
13. Which drug is being requested? Please check drug being requested.	
Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg (if checked, then go to 14)	☐
Actiq (all strengths) (if checked, then go to 14)	☐
Fentora (all strengths) (if checked, then go to 14)	☐
Onsolis 200 mcg, 400 mcg, 600 mcg (if checked, then go to 14)	☐
Lazanda 100 mcg (if checked, then go to 15)	☐
Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg (if checked, then go to 14)	☐
Subsys 1200 mcg, 1600 mcg (if checked, then go to 16)	☐
14. Does the patient's pain require use of MORE than 180 units per month of any of the following: A) Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg, B) Actiq (all strengths), C) Fentora (all strengths), D) Onsolis 200 mcg, 400 mcg, 600 mcg, E) Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg?	Y N
[Note Subsys packaging: Supplied as 1 spray per blister for Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg.]	

[No further questions.]	
15. Does the patient's pain require use of MORE than 360 sprays per month (i.e., 45 bottles per month) of Lazanda 100 mcg?	Y N
[No further questions.]	
16. Does the patient's pain require use of MORE than 360 sprays per month (i.e., 180 blisters per month) of Subsys 1200 mcg or 1600 mcg?	Y N
[Note Subsys packaging: Supplied as 2 sprays per blister for Subsys 1200 mcg and 1600 mcg.]	

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date