

Pharmacy PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Abstral[®] (fentanyl [sublingual tablet])
Onsolis[®] (fentanyl [buccal film])

- URGENT** (life threatening)
 Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

 Provider Signature

 Date

PRODUCT INFORMATION

- Abstral**[®] 100 mcg 200 mcg 300 mcg 400 mcg 600 mcg 800 mcg
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- Onsolis**[®] 200 mcg 400 mcg 600 mcg 800 mcg 1,200 mcg

Start Date: _____ **Dosing frequency:** _____

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for short-acting oral fentanyl requires the following information to certify:

To certify this request, all of the following criteria must be met:

1. The medication is being used only for an FDA-approved indication: Management of breakthrough pain in patients with cancer, 18 years of age and older, who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain.

2. Patients who are considered to be opioid tolerant are those taking morphine 60 mg/day or more, transdermal fentanyl 25 mcg/hr, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for 1 week or longer.

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT
Authorization for short-acting oral fentanyl requires the following information to certify:

1. What is the patient's diagnosis?

- a. Cancer Cancer diagnosis: _____
- b. Other: _____
Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

2. What is the patient's current opioid treatment (regimen must be around-the-clock opioids for persistent cancer pain): _____

3. What other breakthrough pain medications have been tried?

4. Please provide other rationale for use, if necessary:

PHYSICIAN STATEMENT

For Medicare only: If none of the above is applicable to this member, please check which, if any, of the following apply:

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
- a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
- b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
- a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
- b. Based on sound clinical evidence and medical and scientific evidence, the known

relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

- c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** All fields must be complete and legible for Prior Authorization Review*****

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**