

Pharmacy

PRIOR AUTHORIZATION FORM

Last Reviewed: January 2012

New: January 2012

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

Lazanda[®] (fentanyl nasal spray)

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

- Lazanda 100 mcg
 Lazanda 400 mcg

Dose: _____

Start Date: _____ **No. Bottles per 30 days** _____

NOTE: Lazanda, when authorized, will be limited to 6 months of coverage. Additional fills beyond 6 months will require recertification to ensure patient is still receiving around-the-clock opioid pain medicine.

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Brand Name[®] (generic name) requires the following information to certify:

Patient must have met the following requirements:

- 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.
- 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.
- Documented therapeutic trial and clinical failure with two generic opioid pain medications used for management of breakthrough cancer pain

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Lazanda[®] (fentanyl) requires the following information to certify:

A. What is the patient's diagnosis?

- a. breakthrough cancer pain 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.

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

C. What other breakthrough pain medications have been tried (a minimum of 2 generics are required)?

<u>Medication</u>	<u>Dosage</u>	<u>Trial Dates</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

D. Please provide other rationale for use, if necessary: _____

OTHER INFORMATION

Note:

- Patients must not be converted to Lazanda from other fentanyl products because it is not equivalent to other fentanyl products on a mcg per mcg basis, and such substitution could result in a fatal overdose; do not substitute Lazanda for another fentanyl product when being dispensed.
- Do not use more than 1 dose of Lazanda for an episode of breakthrough cancer pain

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX