Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Abstral® (fentanyl citrate sublingual tablet)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product:

- ☐ Abstral 100 mcg
- ☐ Abstral 200 mcg
- ☐ Abstral 300 mcg
- ☐ Abstral 400 mcg
- ☐ Abstral 600 mcg
- ☐ Abstral 800 mcg

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Diagnosis of breakthrough pain in cancer patients
2. Age 18 years or older
3. Patient is already receiving and is tolerant to opioid therapy for underlying persistent cancer pain
4. Prescriber must be enrolled in the TIRF REMS Access Program
5. Patient must sign the Patient-Prescriber Agreement form for the TIRF REMS program

(Patients are considered opioid tolerant when taking oral morphine 60 mg/day or more, transdermal fentanyl 25 mcg/hr, oral oxycodone 30 mg/day, oral hydromorphone 8 mg/day, oral oxymorphone 25 mg/day, oral hydrocodone 60mg/day, or an equianalgesic dose of another opioid for 1 week or longer.)

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2017

Last reviewed 11/2018

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ Breakthrough pain due to cancer Date of cancer diagnosis: _____

☐ *Other – the patient's condition is:* _____

B. Is the patient already receiving and tolerant to opioid therapy?

☐ Yes ☐ No

C. Is the prescriber enrolled in the TIRF REMS program?

☐ Yes ☐ No

D. Has the patient signed the Patient-Prescriber Agreement form (part of the TIRF REMS program)?

☐ Yes ☐ No

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Abstral likely be the most effective option for this patient?

☐ Yes ☐ No

If yes, please explain why: _____

_____

_____

If the patient is currently using Abstral, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ Yes ☐ No

If yes, please explain: _____

_____

_____

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Last reviewed 11/2018