

# Pharmacy Prior Authorization Form

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

This form applies to:  **Commercial (Traditional)**     **Commercial (Individual/Optimized)**

**Medicaid**

This request is:  **Urgent** (life threatening)     **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

## Fentora<sup>®</sup> (fentanyl citrate buccal 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:  Fentora 100 mcg tablet  
 Fentora 200 mcg tablet  
 Fentora 400 mcg tablet  
 Fentora 600 mcg tablet  
 Fentora 800 mcg tablet

**Start date** (or date of next dose): \_\_\_\_\_

**Date of last dose** (if applicable): \_\_\_\_\_

**Dosing frequency:** \_\_\_\_\_

### Precertification Requirements

**Before this drug is covered, the patient must meet all of the following requirements:**

1. This drug is being used to manage breakthrough pain in cancer patients already receiving and tolerant to around-the-clock opioid therapy for persistent cancer pain
2. Age 18 or older

Note: 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.

**Note:** Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

### Priority Health Precertification Documentation

#### 1. What condition is this drug being requested for?

Breakthrough cancer pain  
*Cancer diagnosis:* \_\_\_\_\_

Other – the patient's condition is: \_\_\_\_\_  
*Rationale for use:* \_\_\_\_\_

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

<b>Drug</b>	<b>Dose</b>	<b>Dates</b>
_____	_____	_____
_____	_____	_____

**3. What other breakthrough pain medications have been tried?**

<b>Drug</b>	<b>Dose</b>	<b>Dates</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

\_\_\_\_\_

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