PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form 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.

Lazanda® (fentanyl citrate nasal spray)

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:
- ☐ Lazanda 100 mcg
- ☐ Lazanda 300 mcg
- ☐ Lazanda 400 mcg

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Prior authorization criteria

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
3. Must first try two generic opioid drugs to manage breakthrough pain

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.

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: _____

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

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

Drug	Dose	Dates

3. What other breakthrough pain medications have been tried?

Drug	Dose	Dates

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

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.

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Last reviewed 11/2018