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.

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.

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 11/2019

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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):

Drug	Dose	Dates

3. What other breakthrough pain medications have been tried?

Drug	Dose	Dates

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

_____
_____
_____

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Last reviewed 11/2019