

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.

Lazanda[®] (fentanyl 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 400 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 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.)

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, the DRUGDEX Information System, and the USPDI or its successor.)

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

(Patients are considered to be opioid tolerant when 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.)

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 Lazanda likely be the most effective option for this patient?

- No
 Yes, because: _____

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

- No
 Yes, because: _____