Prior Authorization Form

Fentora

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Fentora.

Drug Name (select from list of drugs shown)

Fentanyl Buccal Tablet Fentora (fentanyl buccal tablet)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. Is the requested drug being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain? If yes, then prescriber MUST submit chart notes or other documentation supporting a diagnosis of cancer-related pain AND list type of cancer _____

Y N

[Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED DIAGNOSIS.]

2. Have chart notes or other documentation supporting a diagnosis of cancer-related pain been submitted to CVS Health?	Y N
3. Which drug is being requested? Please check the drug being requested.	
[Note: Ensure that the patient can safely take the requested dose based on their history of opioid use.]	
Abstral 600 mcg or 800 mcg (if checked, then go to 4)	☐
Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg (if checked, then go to 6)	☐
Actiq (all strengths) (if checked, then go to 6)	☐
Fentora (all strengths) (if checked, then go to 6)	☐
Lazanda 100 mcg (if checked, then go to 7)	☐
Lazanda 300 mcg or 400 mcg (if checked, then go to 5)	☐
Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg (if checked, then go to 6)	☐
Subsys 1200 mcg, 1600 mcg (if checked, then go to 8)	☐
4. Coverage is provided for up to 120 units per month of Abstral 600 mcg, 800 mcg. Is MORE than this quantity needed to manage the patient's pain?	Y N
[No further questions.]	
5. Coverage is provided for up to 240 sprays per month (i.e., 30 bottles per month) of Lazanda 300 mcg, 400 mcg. Is MORE than this quantity needed to manage the patient's pain?	Y N
[No further questions.]	
6. Coverage is provided for up to 120 units per month of the following: A) Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg, B) Actiq (all strengths), C) Fentora (all strengths), D) Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg. If higher quantities are needed, then additional questions are required. Is MORE than this quantity needed to manage the patient's pain?	Y N
[Note Subsys packaging: Supplied as 1 spray per blister for Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg.]	
[If no, then no further questions.]	
[If yes, then skip to question 9.]	
7. Coverage is provided for up to 240 sprays per month (i.e., 30 bottles per month) of Lazanda 100 mcg. If higher quantities are needed, then additional questions are required. Is MORE than this quantity needed to manage the patient's pain?	Y N

[If no, then no further questions.]	
[If yes, then skip to question 9.]	
8. Coverage is provided for up to 240 sprays per month (i.e., 120 blisters per month) of Subsys 1200 mcg or 1600 mcg. If higher quantities are needed, then additional questions are required. Is MORE than this quantity needed to manage the patient's pain?	Y N
[Note Subsys packaging: Supplied as 2 sprays per blister for Subsys 1200 mcg and 1600 mcg.]	
[If no, then no further questions.]	
9. Is the patient's dose of a concomitant long-acting analgesic being increased?	Y N
[If yes, then skip to question 11.]	
10. Are additional quantities of the requested drug needed for breakthrough pain because the dose of the patient's long-acting analgesic is unable to be increased?	Y N
[If no, then no further questions.]	
11. Which drug is being requested? Please check the drug being requested.	
[Note: Ensure that the patient can safely take the requested dose based on their history of opioid use.]	
Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg (if checked, then go to 12)	☐
Actiq (all strengths) (if checked, then go to 12)	☐
Fentora (all strengths) (if checked, then go to 12)	☐
Lazanda 100 mcg (if checked, then go to 13)	☐
Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg (if checked, then go to 12)	☐
Subsys 1200 mcg, 1600 mcg (if checked, then go to 14)	☐
12. Does the patient's pain require use of MORE than 180 units per month of any of the following: A) Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg, B) Actiq (all strengths), C) Fentora (all strengths), D) Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg?	Y N
[Note Subsys packaging: Supplied as 1 spray per blister for Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg.]	
[No further questions.]	
13. Does the patient's pain require use of MORE than 360 sprays per month (i.e., 45 bottles per month) of Lazanda 100 mcg?	Y N
[No further questions.]	

14. Does the patient's pain require use of MORE than 360 sprays per month (i.e., 180 blisters per month) of Subsys 1200 mcg or 1600 mcg?	Y N
[Note Subsys packaging: Supplied as 2 sprays per blister for Subsys 1200 mcg and 1600 mcg.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date