Prescriber Criteria Form

Fentanyl Patch 2025 PA Fax 1398-A v1 010125.docx
Fentanyl Transdermal System
Coverage Determination

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 **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Fentanyl Transdermal System.

Drug Name:
Fentanyl Transdermal System

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for pain associated with any of the following: A) cancer, B) sickle cell disease, C) a terminal condition, D) pain being managed through palliative care? [If yes, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid? [If no, then no further questions.]	Yes ◯	No ◯
3	Can the patient safely take the requested dose based on their history of opioid use? [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient been evaluated, and will the patient be monitored for the development of opioid use disorder? [If no, then no further questions.]	Yes ◯	No ◯

5	Is this request for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days? [If yes, then no further questions.]	Yes ◯	No ◯
6	Has the patient taken an immediate-release opioid for at least one week?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____