Prescriber Criteria Form

Oral Intranasal Fentanyl 2024 PA Fax 1445-A v1 010124.docx
Oral/Intranasal Fentanyl Products
Actiq (fentanyl citrate oral transmucosal lozenge), Fentora (fentanyl citrate buccal tablet), Lazanda (fentanyl nasal spray), Subsys (fentanyl sublingual spray)
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 Oral/Intranasal Fentanyl Products.

Drug Name (select from list of drugs shown):

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	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 with underlying cancer pain? [If no, then no further questions.]	Yes	No
2	Does the International Classification of Diseases (ICD) diagnosis code provided support the cancer-related diagnosis? [Note: For drug coverage approval, ICD diagnosis code provided MUST support the cancer-related diagnosis.] [If no, then no further questions.]	Yes	No
3	Is the patient currently receiving, and will continue to receive, around-the-clock opioid therapy for underlying cancer pain? [If no, then no further questions.]	Yes	No
4	The requested drug is intended only for use in opioid tolerant patients. Can the patient safely take the requested dose based on their current opioid use history? [Note: Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg of oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg of oral	Yes	No

	oxymorphone per day, or an equianalgesic dose of another opioid medication daily for one week or longer.]		

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:____________________