



CONTAINS CONFIDENTIAL PATIENT INFORMATION

Actiq (oral transmucosal fentanyl citrate)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Form with fields for Patient Name, ID, DOB, Date of Rx, Phone, Email, Prescribing Physician, Address, Phone, Fax, Specialty, DEA, NPI, and Email Address.

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QTY REQUESTED PER 30 DAYS

Form with fields for Actiq (oral transmucosal fentanyl citrate), strength options (200 ug to 1600 ug), directions, and quantity requested (Specify: Max Qty: 120 per 30 days).

7. DIAGNOSIS:

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Form with approval criteria questions: Is the patient 16 years of age or older? Does the patient have a diagnosis of cancer with breakthrough cancer pain? Is the patient already receiving opioid therapy and is TOLERANT to opioid therapy defined as (please mark appropriate box)? Has the physician discussed the appropriate disposal of unused medication with the patient?

9. PHYSICIAN SIGNATURE

Form with fields for Prescriber or Authorized Signature and Date.

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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