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

Patient Name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

Patient Phone #: _____

Patient Email Address: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: _____

Physician Address: _____

Physician Phone #: _____

Physician Fax #: _____

Physician Specialty: _____

Physician DEA: _____

Physician NPI #: _____

Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QTY REQUESTED PER 30 DAYS
Actiq (oral transmucosal fentanyl citrate)	□ 200 ug □ 400 ug □ 600 ug □ 800 ug □ 1200 ug □ 1600 ug	_____	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.

□ Yes □ No Is the patient 16 years of age or older

□ Yes □ No Does the patient have a diagnosis of cancer with breakthrough cancer pain
If not, please provide diagnosis: _____
_____

□ Yes □ No Is the patient already receiving opioid therapy and is TOLERANT to opioid therapy defined as **(please mark appropriate box)**:

- □ Yes □ No At least 60 mg of morphine per day
- □ Yes □ No At least 25 mcg of transdermal fentanyl per hour
- □ Yes □ No At least 30mg of oxycodone
- □ Yes □ No At least 8mg of oral hydromorphone daily
- □ Yes □ No An equianalgesic dose of another opioid for a week or longer

□ Yes □ No Has the physician discussed the appropriate disposal of unused medication with the patient

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature 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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