PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Butrans® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

For states, such as AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:

Will the requested medication be used for the treatment of a terminal condition or associated symptoms? ❑ **Yes** ❑ **No**

If "YES", please indicate the patient's estimated life expectancy:

❑ Less than 6 months ❑ Less than_____months (please specify)

Select the diagnosis below:

❑ Severe pain

❑ Other diagnosis:____________________________________ ICD-10 Code(s): ____________________________________

Clinical information:

Is the patient under hospice care? ❑ **Yes** ❑ **No**

Does the patient require continuous, around-the-clock opioid analgesic for an extended period of time (at least 2 weeks)? ❑ **Yes** ❑ **No**

Does the patient have documented swallowing difficulties? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Fentanyl transdermal patch

❑ Methadone

❑ Morphine sulfate extended-release (ER) product

❑ Oxymorphone ER

❑ Tramadol ER

❑ Other generic extended-release opioid product(s) and/or opioid combination product(s).
Please specify: ____

Quantity limit requests:

What is the quantity requested per MONTH?_________

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: ____

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Office use only: Butrans_Jan_2018

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): ______________________ **Date:** __________

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	

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