PRO ACT
PHARMACY BENEFIT MANAGEMENT

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

Nasal and Oral Fentanyl Products 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**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

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:

Does the patient have a diagnosis of cancer? ❑ **Yes** ❑ **No**

If yes to the above, is the requested medication used to manage breakthrough pain due to cancer? ❑ **Yes** ❑ **No**

❑ Other diagnosis:_____ ICD-10 Code(s):_ _____

Select any of the following which the patient has at least a one week history of:

❑ An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day)
❑ Duragesic (fentanyl transdermal patch) at doses greater than or equal to 25 µg/hour
❑ Morphine sulfate at doses of greater than or equal to 60 mg/day
❑ Oral oxymorphone at a dose of greater than or equal to 25 mg/day
❑ Oral hydromorphone at a dose of greater than or equal to 8 mg/day
❑ Oxycodone at a dose of greater than or equal to 30 mg/day

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

❑ Fentanyl lozenge (generic Actiq)
❑ Hydromorphone immediate-release (IR)
❑ Morphine sulfate IR
❑ Oxymorphone IR
❑ Oxycodone IR

Current treatment:

Is the patient currently taking a long-acting opioid around the clock for cancer pain? ❑ **Yes** ❑ **No**

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Prescriber specialty:

Select which of the following specialists the medication was prescribed by:

❑ Hematologist ❑ Hospice care specialist ❑ Oncologist ❑ Pain specialist ❑ Palliative care specialist
❑ Other_____

Select which of the following specialists the medication was prescribed in consultation with:

❑ Hematologist ❑ Hospice care specialist ❑ Oncologist ❑ Pain specialist ❑ Palliative care specialist
❑ Other_____

Quantity limit requests:

What is the quantity being requested per DAY: _____

Select all of the following that have been maintained and documented in chart notes:

❑ A description of the nature and intensity of the pain
❑ An appropriate patient medical history
❑ An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
❑ Appropriate dose escalation
❑ Ongoing, periodic review of the course of opioid therapy
❑ Patient physical examination
❑ Verification that the risks and benefits of the use of the controlled substance have been discussed with the patient, significant other(s), and/or guardian

Chart documentation:

Will chart documentation be submitted to *ProAct*® with this form, confirming the above information? ❑ **Yes** ❑ **No**

***Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.*

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:	