Maryland Pharmacy Program
Request for Rx Prior Authorization
Transmucosal Fentanyl (Actiq®, Fentora®)

11963

Request Date ☐☐ / ☐☐ / ☐☐☐☐

PATIENT INFORMATION

Patient's Medicaid ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Patient's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Patient's Full Name

Patient Location: ○ **Outpatient** ○ **Nursing Home or Skilled Nursing Facility**

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City **State** **Zip Code** ☐☐ ☐☐☐☐☐ - ☐☐☐☐

Prescriber Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Prescriber Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

NPI# ☐☐☐☐☐☐☐☐☐☐

Transmucosal fentanyl (Actiq®, Fentora®) Prior Authorization Criteria - Patient must meet all five

○ **Yes** ○ **No** **1. Diagnosis of cancer. State specific cancer diagnosis** _____

○ **Yes** ○ **No** **2. Age 16 years or greater.**

○ **Yes** ○ **No** **3. Under the care of an oncologist or pain specialist who is experienced in the use of Schedule II opioids to treat cancer pain.**

○ **Yes** ○ **No** **4. Currently receiving and tolerant to long-acting opioid therapy. (i.e. patient is taking at least 60 mg. of morphine per day, 50 mcg. transdermal fentanyl/hour or an equi-analgesic dose of another long-acting opioid for a week or longer).**

○ **Yes** ○ **No** **5. Does not have any of the following contraindications: hypersensitivity to opiates; hypoxia/hypercarbia; severe asthma or chronic obstructive pulmonary disease; or paralytic ileus.**

List all current opioid therapy and duration of use:

Drug	Total Daily Dose	Duration of Therapy

I certify that use of transmucosal fentanyl (Actiq®, Fentora®) for this patient is consistent with the FDA approved labeling.

Date ☐☐ / ☐☐ / ☐☐☐☐

Signature of Prescriber_____

Is prescriber a Pain Management Specialist or Oncologist? ○ **Yes** ○ **No**

If no, indicate area of practice (such as Internal Medicine, Family Practice). _____

FAX TO: Maryland Pharmacy Program

Fax: (866) 440 - 9345

PA HELPDESK: (800)932-3918

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Revised - March 11, 2009