Maryland Medicaid Pharmacy Program
Request for Rx Prior Authorization
Transmucosal Fentanyl

11963

Request Date ___ / ___ / ____

PATIENT'S INFORMATION

Patient's Medicaid ID Number

Patient's Date of Birth ___ / ___ / ____

Patient's Full Name

Patient's Location: ○ Outpatient ○ Nursing Home or Skilled Nursing Facility

PRESCRIBER'S INFORMATION

Prescriber's Full Name

Prescriber's Street Address

City

State

Zip Code -

Prescriber's Phone: - -

Prescriber's Fax: - -

NPI#

Transmucosal Fentanyl Prior Authorization Criteria - Patient must meet all five criteria below:

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

○ Yes ○ No 2. Age 18 years or greater (16 yrs for Actiq).

○ 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 the use of transmucosal fentanyl for this patient is consistent with the FDA approved labeling.

Signature of Prescriber_____ Date ___ / ___ / ____

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

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

FAX TO: Maryland Medicaid Pharmacy Program

Fax: (866) 440 - 9345

PA HELPDESK: (800)932-3918

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