Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

FENTANYL CITRATE
Prior Authorization Form

ABSTRAL, FENTANYL CITRATE, FENTORA, LAZANDA, ONSOLIS, AND SUBSYS

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Diagnosis:	Date Diagnosed:

Does the member have a breakthrough cancer pain? □ Yes □ No

Does the member have acute or postoperative pain? □ Yes □ No

If yes, please explain:_____

Is the member on a long-acting opioid? □ Yes □ No

If yes, please list specific agents below:_____

Has the member tried and failed generic transmucosal fentanyl citrate? □ Yes □ No

Has the member tried and failed Abstral (if requesting a different brand product)? □ Yes □ No

History of Medications Used to Treat Above Condition

□ No other medications have been used to treat this condition

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	