OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service

Abstral®, Actiq® (fentanyl lozenge), Fentora®, Lazanda® & Subsys®
Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

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:
	Directions for Use:	

Clinical Information (required)	
1. Is the requested medication being used for the management of breakthrough cancer pain?	❑ Yes ❑ No
2. Does the patient have at least a one-week history of ONE of the following medications to demonstrate tolerance to opioids? • Fentanyl transdermal patch at doses greater than or equal to 25 µg/hr • Morphine sulfate at doses of greater than or equal to 60 mg/day • Oral hydromorphone at a dose of greater than or equal to 8 mg/day • Oral oxymorphone at a dose of greater than or equal to 25 mg/day • Oxycodone at a dose of greater than or equal to 30 mg/day • An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day)	❑ Yes ❑ No
3. Does the patient have a history of failure of or intolerance to generic fentanyl lozenge?	❑ Yes ❑ No
4. Is the patient currently taking a long-acting opioid around the clock for cancer pain?	❑ Yes ❑ No
5. Is the requested medication prescribed by or in consultation with ONE of the following? • Hematologist • Hospice care specialist • Oncologist • Pain specialist • Palliative care specialist	❑ Yes ❑ No
Quantity limit: Also answer the following:	
1. Does the prescriber maintain and will provide chart documentation of the patient's evaluation, including ALL of the following? *Chart documentation must be submitted.* • A description of the nature and intensity of the pain • An appropriate patient medical history and physical examination • 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) • Documentation of appropriate dose escalation • Documentation of ongoing, periodic review of the course of opioid therapy • 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	❑ Yes ❑ No

This document – and others if attached – contains information that is privileged, confidential and/or may contain protected health information (PHI). The provider named above is required by applicable law to safeguard PHI. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Abstral®, Actiq® (fentanyl lozenge), Fentora®, Lazanda® & Subsys®
Prior Authorization Request Form (Page 2 of 2)

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

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.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern

This document – and others if attached – contains information that is privileged, confidential and/or may contain protected health information (PHI). The provider named above is required by applicable law to safeguard PHI. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**