

Prior Authorization Form

CAREFIRST

Influenza Treatment and Prevention Post Limit 111-J

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Abstral.

Drug Name (select from list of drugs shown)

Abstral (fentanyl citrate sublingual tablet)

Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

Note: ICD Code must support diagnosis for requested drug.

- Does the patient have significant respiratory depression or known or suspected paralytic ileus? Y N
- This drug is indicated for the treatment of breakthrough CANCER related pain only. Does the patient have CANCER related pain? If yes, prescriber MUST submit _____ Y N

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chart notes or other documentation supporting a diagnosis of cancer related pain AND list type of cancer.	
[Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER RELATED DIAGNOSIS.]	
3. Have chart notes or other documentation supporting a diagnosis of cancer related pain been submitted to CVS Health by fax?	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Is the drug being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain?	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Can the patient safely take the requested dose based on their current opioid use history?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: The TIRF (Transmucosal Immediate-Release Fentanyl) products (Abstral, Actiq, Fentora, Lazanda, Onsolis, and Subsys) are indicated for opioid- tolerant patients. Patients considered opioid tolerant are those who are taking at least: 60 mg of oral morphine/day, 25 mcg of transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for a week or longer.]	
6. Is Lazanda the drug being requested?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 12.]	
7. Coverage is provided for up to 240 sprays per month (i.e., 30 bottles per month) of Lazanda. If higher quantities are needed, additional questions are required. Is MORE than this quantity needed to manage the patient's pain?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
8. Is the patient's dose of a concomitant long-acting analgesic being increased?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, then skip to question 10.]	
9. Are additional quantities of the requested drug needed for breakthrough pain because the dose of the patient's long-acting analgesic is unable to be increased?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Is this request for Lazanda 300 mcg or 400 mcg?	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Does the patient's pain require use of MORE than 360 sprays per month (i.e., 45 bottles per month) of Lazanda 100 mcg?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
12. Coverage is provided for up to 120 units per month of Abstral, Actiq, Fentora, Onsolis, or Subsys. If higher quantities are needed, additional questions are required. Is MORE than this quantity needed to manage the patient's pain?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
13. Is the patient's dose of a concomitant long-acting analgesic being increased?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, then skip to question 15.]	

14. Are additional quantities of the requested drug needed for breakthrough pain because the dose of the patient's long-acting analgesic is unable to be increased?	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Is this request for Abstral 600 mcg, Abstral 800 mcg, Onsolis 800 mcg, or Onsolis 1200 mcg?	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Does the patient's pain require use of MORE than 180 units per month of Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg, Actiq (all strengths), Fentora (all strengths), Subsys (all strengths), or Onsolis 200 mcg, 400 mcg, 600 mcg?	<input type="checkbox"/> Y <input type="checkbox"/> N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date