CareFirst Family of health care plans

CVS/caremark

Prior Authorization Form

CAREFIRST

Onsolis

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 Onsolis.

Drug Name (select from list of drugs shown)

Onsolis (fentanyl citrate buccal soluble film)

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.

1.	Does the patient have significant respiratory depression or known or suspected paralytic ileus?	Y N
2.	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 chart notes or other documentation supporting a diagnosis of cancer related pain AND list type of cancer.	Y N
	[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?	Y 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?	Y N

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5.	Can the patient safely take the requested dose based on their current opioid use history?	Y 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?	Y 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?	Y N
	[If no, then no further questions.]	
8.	Is the patient's dose of a concomitant long-acting analgesic being increased?	Y 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?	Y N
10.	Is this request for Lazanda 400 mcg?	Y 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?	Y 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?	Y N
	[If no, then no further questions.]	
13.	Is the patient's dose of a concomitant long-acting analgesic being increased?	Y 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?	Y N
15.	Is this request for Abstral 600 mcg, Abstral 800 mcg, Onsolis 800 mcg, or Onsolis 1200 mcg?	Y 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?	Y N

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

Prescriber (Or Authorized) Signature and Date