Transmucosal Fentanyl (Actiq®, Fentora®, Onsolis™, Abstral®)

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

Requested Drug and Strength:____

Requested Quantity for 30 days:___________________________

Note: *Quantity Limit of 120 units per 30 days. Patients should limit consumption to 4 or fewer units per day.*

- *Actiq (including generic fentanyl citrate): 120 lozenges per 30 days*
- *Fentora, Abstral: 120 tablets per 30 days*
- *Onsolis: 120 films per 30 days*

Please answer the following questions:

1) Is the requested drug being prescribed for the management of breakthrough pain due to cancer?............ ☐Yes ☐No

2) Is the requested drug being prescribed for acute or post-operative pain?............ ☐Yes ☐No

3) Is the patient currently receiving a long-acting opioid analgesic (e.g., methadone, sustained-release morphine, oxycodone controlled-release tablets [OxyContin®], or fentanyl transdermal system [Duragesic®]) for treatment of chronic pain?............ ☐Yes ☐No

4) Is the patient tolerant to a long-acting opioid analgesic?............ ☐Yes ☐No
Patients considered opioid tolerant are those who are taking, for one week or longer,
   - *at least 60 mg morphine/day,*
   - *at least 25 mcg transdermal fentanyl/hour,*
   - *at least 30 mg of oxycodone daily,*
   - *at least 8 mg oral hydromorphone daily,*
   - *at least 25 mg oral oxymorphone daily, or*
   - *an equianalgesic dose of another opioid.*

5) This request for fentanyl represents:............
☐New start on transmucosal fentanyl therapy ☐Continuation of transmucosal fentanyl therapy

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required):________________________________Date:________________

***Fax completed form to* 1-800-795-9403**

Last Revision Date: 1/19/10