



FENTANYL: TRANSMUCOSAL (ACTIQ®, FENTORA®, ONSOLIS™, ABSTRAL®) INTRANASAL (LAZANDA®) SUBLINGUAL SPRAY (SUBSYS®)

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

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

Table with 2 main columns: PRESCRIBER INFORMATION and PATIENT INFORMATION. Rows include fields for Physician Name, Provider ID/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, and 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. Onsolis: 120 films per 30 days. Lazanda: 120 nasal sprays (dosages) per 30 days. Fentora, Abstral: 120 tablets per 30 days. Subsys: 120 sublingual sprays (dosages) per 30 days.

Please answer the following questions:

- 1) Is the requested drug being prescribed for the management of breakthrough pain due to cancer?
2) Is the requested drug being prescribed for acute or post-operative pain?
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?
4) Is the patient tolerant to a long-acting opioid analgesic?
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: _____