



**Transmucosal Fentanyl (Actiq<sup>®</sup>, Fentora<sup>®</sup>, Onsolis<sup>™</sup>)  
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: 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) Have other oral immediate-release opioids been tried and failed, or the patient is unable to take them? .....  Yes  No
- 4) Is the patient currently receiving a long-acting opioid analgesic (e.g., methadone, sustained-release morphine, oxycodone controlled-release tablets [OxyContin<sup>®</sup>], or fentanyl transdermal system [Duragesic<sup>®</sup>]) for treatment of chronic pain? .....  Yes  No
- 5) 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.

**Other Pertinent Information:**

I certify that the above information is accurate and **is documented in the medical record.**

Prescriber's Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_

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