Actiq®, Fentora®, Onsolis®

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date:	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: to

Not to exceed 6 months for initial therapy. Additional therapy may be approved for up to 1 year.

Actiq® and Onsolis® are limited to 4 units per day. Fentora® is limited to 6 tablets per day

Question	Yes	No	Comments/Notes
12. Please select the agent being requested: ☐ Actiq® (fentanyl citrate transmucosal) ☐Fentora® (fentanyl buccal tablet) ☐Onsolis® (fentanyl buccal soluble film)			
13. Will the patient's pain management be administered solely by your office?			
14. Does the patient have cancer associated with breakthrough cancer pain or a terminal disease with breakthrough pain			
15. Please select at least two opioid drug regimens that the patient has tried and failed, using the highest tolerated dose for at least 14 days: ☐ oxycodone ☐ methadone ☐ morphine ☐ fentanyl ☐ hydromorphone			Verification will be made by reviewing the patient's drug history or patient chart notes.
16. Please indicate if the patient is currently receiving any the following: ☐≥60 mg of morphine per day ☐ ≥50 mcg per hour of transdermal fentanyl ☐ ≥30 mg of oxycodone per day ☐ ≥8 mg of hydromorphone per day ☐ ≥300 mg of meperidine per day			Verification will be made by reviewing the patient's drug history or patient chart notes.
17. Please list the maintenance opioid therapy that the patient will continue while receiving the requested therapy:			Include dosing and strength.
18. Has the patient tried and failed at least an 8-week therapy of the highest tolerated dose of generic fentanyl citrate lozenges?			
19. Physician's Signature: _____			