

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
FENTANYL, SHORT ACTING ORAL PRODUCTS
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #: _____	Patient Name: _____	DOB: _____
Patient Address: _____		
Provider NPI: _____	Prescriber Name: _____	Phone: _____
Prescriber Address: _____		Fax: _____
Pharmacy Name: _____	Address: _____	Phone: _____
Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.		
Pharmacy NPI: _____	Pharmacy Fax: _____	NDC : _____

Prior authorization is required for short acting oral fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. Short acting oral fentanyl products: :

- Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain.
- Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.

PLEASE NOTE THERE IS A BLACK BOX WARNING FOR THIS PRODUCT

Non-Preferred

- | | | |
|----------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> Abstral | <input type="checkbox"/> Fentora | <input type="checkbox"/> Subsys |
| <input type="checkbox"/> Actiq | <input type="checkbox"/> Onsolis | |

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

- Breakthrough Cancer Pain (no malignancies)
- Breakthrough Cancer Pain (with malignancies)
- Other (specify): _____

Prescriber Specialty:

- Oncologist
- Pain management specialist
- Other (specify): _____

Current opioid therapy: Drug Name _____ Strength _____

Dosage instructions _____ Opioid duration of therapy: _____ weeks/months/years (circle)

Additional relevant information: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.