

FENTANYL OT LOZENGE

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Will the oral fentanyl product (e.g., Actiq, Fentora) be used to manage breakthrough pain due to a current cancer condition or complication?
[If the answer to this question is no, no further questions are required.] Y N
2. Is a long-acting opioid being prescribed for around-the-clock treatment of the cancer pain? Y N
3. Is the patient opioid tolerant? (Patients are considered opioid tolerant if they are tiling at least 60 mg of morphine per day, or an equianalgesic dose of another opioid, for a week or longer.)? Y N
4. Is the patient taking a strong or moderate cytochrome P450 3A4 inhibitor(s) (e.g., ritonavir, ketoconazole, itraconazole, troleandomycin, clarithromycin, nelfinavir, nefaxzodone or amprenavir, aprepitant, diltazem, erythromycin, fluconazole, fosamprenavir or verapamil)? Y N
5. Will the patient be carefully monitored and will dosage adjustments be made if necessary? Y N

Comments: _____

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Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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