



Prior Authorization Form

Fentora®/Opana®/Opana ER®/Magnacet®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [ ] Fentora® [ ] Opana® [ ] Magnacet® [ ] Opana ER® [ ] Other (specify) \_\_\_\_\_

Dose \_\_\_\_\_ \*Quantity \_\_\_\_\_

Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

\* Fentora is limited to 120 tablets per 30 days, Opana is limited to 180 tablets per 30 days, Opana ER to 90 tablets per 30 days, and Magnacet to 180 tablets per 30 days

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1. PROVIDER SPECIALTY (specify all) \_\_\_\_\_

2. DIAGNOSIS FOR DRUG REQUESTED:

[ ] Breakthrough pain associated with cancer [ ] Other (specify) \_\_\_\_\_

3. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[ ] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes blank rows for entry.

4. PATIENT HISTORY:

(Fentora only)

a. Is the patient tolerant to current opioid therapy (at least 60mg of oral morphine/day or an equi-analgesic dose of another opioid)? [ ] Yes [ ] No

b. Has the patient tried and failed an oral transbuccal fentanyl citrate (Actiq®) for at least one week or longer? [ ] Yes [ ] No

(Magnacet only)

c. Is there a reason why an oxycodone/acetaminophen containing product with greater than 400mg of acetaminophen would not be appropriate? [ ] Yes [ ] No

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only. Document #, Coverage effective date, Processor Initials, Date, M F Rx coverage Y N, STANDARD - SELECT, LOB, Previous Auth Y N, Approved, Reviewer Initials, Date.