AmeriHealth

Prior Authorization Form

Controlled Substance: Prior authorization/Quantity Limit/Duplicate Therapy

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: ☐ **Fentora®** ☐ **Opana®** ☐ **Magnacet®** ☐ **Actiq®** ☐ **Fentanyl Citrate**
☐ **Opana ER®** ☐ **Nucynta®** ☐ **Other (specify)** _____

Dose _____ ***Quantity** _____

Date: _____ Patient ID#: _____ DOB:_____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

1. PROVIDER SPECIALTY (specify all) _____

2. DIAGNOSIS FOR DRUG REQUESTED:_____

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

☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

4. PATIENT HISTORY:

a. Is the patient on Hospice? ☐ Yes ☐ No ☐N/A

ACTIQ AND FENTORA ONLY:

b. 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 ☐N/A

c. Has the patient tried and failed an oral transbuccal fentanyl citrate (Actiq®)?
☐ Brand ☐ Generic ***Must specify Date and Duration in the Medication History*** ☐ Yes ☐ No ☐N/A

RE-AUTHORIZATION REQUESTS ONLY:

d. Provide evidence to support efficacy associated with current regiment (eg. Pain scores, clinical response):

_____

_____

DUPLICATE THERAPY REQUESTS ONLY:

e. Does the patient have contraindication or intolerance to higher doses of a **single** opioid? ☐ Yes ☐ No ☐N/A

If the request is for duplicate therapy, please provide rationale for a requested combination. ***Please add any other supporting medical information that may be useful in the decision-making process:***

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_____

_____

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

Internal use only **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____

❋ Please refer to "Controlled Substances Quantity Limit-**Effective 05/01/2009**" policy for quantity limits

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