AmeriHealth

## Prior Authorization Form

# Fentora®/Opana®/Opana ER®/Magnacet®/Actiq®

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested: ☐ **Fentora®** ☐ **Opana®** ☐ **Magnacet®** ☐ **Actiq lozenge®** ☐ **Fentanyl Citrate lozenge** ☐ **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, Magnacet to 180 tablets per 30 days and generic and brand Actiq to 120 units per 30 days**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

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."

| Drug Name | Date | Duration |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

4. **PATIENT HISTORY:**

**(Fentora®, generic Actiq®, brand Actiq®):**

**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 ☐ N/A

**b.** Has the patient tried and failed an oral transbuccal fentanyl citrate (Actiq®) for at least one week or longer? ☐ Brand ☐ Generic ☐ Yes ☐ No ☐ N/A

**(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 ☐ N/A

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** **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

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



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