



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Duragesic Post Limit (Medicare Prior Auth)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Duragesic Post Limit (Medicare Prior Auth).

Drug Name (select from list of drugs shown)
Duragesic

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|--|---|---|
| 1. Is the patient 2 years of age or older?
[If the answer to this question is no, then no further questions are required.] | Y | N |
| 2. Does the patient have a diagnosis of cancer related pain?
[If the answer to this question is yes, then skip to question 6.] | Y | N |
| 3. Does the patient have a diagnosis of persistent, moderate to severe chronic pain? | Y | N |
| 4. Has the patient been assessed for clinical risks of opioid abuse and/or addiction by one of the following tools, or another assessment tool for opioid abuse: CAGE questionnaire, Cyr-Wartman Screen, Skinner Trauma Screen, Screener and Opioid Assessment for Patients with Pain (SOAPP)? | Y | N |
| 5. Does the patient require a dose greater than 300 micrograms per hour every 72 hours? | Y | N |
| 6. Does the patient require continuous opioid analgesia? | Y | N |
| 7. Is the patient opioid tolerant? (Patients are considered opioid-tolerant if they have been taking at least 60 mg of morphine daily, or an equianalgesic dose of another opioid, for a week or longer.) | Y | N |



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

- | | | |
|--|---|---|
| 8. Does the patient require Duragesic / transdermal fentanyl more often than every 48 hours? | Y | N |
| 9. Is the patient taking any cytochrome P450 3A4 inhibitors (e.g., ritonavir, ketoconazole, itraconazole, troleandomycin, clarithromycin, nelfinavir, nefazodone, amiodarone, amprenavir, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, grapefruit juice, or verapamil)?
[If the answer to this question is no, then no further questions are required.] | Y | N |
| 10. Will the patient be carefully monitored and will dosage adjustments be made if necessary? | Y | N |

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date