Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Fentanyl Oral 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 Fentanyl Oral Post Limit (Medicare Prior Auth).

Drug Name (select from list of drugs shown)
Fentanyl Citrate Lozenge

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. Will the oral fentanyl product (e.g., Actiq, Fentora) be used to manage breakthrough cancer pain? Y N
   [If the answer to this question is no, then no further questions are required.]
2. Are more than 4 units per day required? Y N
   [If the answer to this question is no, then no further questions are required.]
3. Are more than 4 units per day required while adjusting/increasing the patient's concomitant long-acting analgesic? Y N
   [If the answer to this question is yes, then no further questions are required.]
4. Are more than 4 units per day required because of increased or more frequent breakthrough pain? Y N
   [If the answer to this question is no, then no further questions are required.]
5. Are more than 4 units per day required because the member is unable to tolerate or experiences inadequate pain control with fewer doses of a higher strength of oral fentanyl? Y N
   [If the answer to this question is yes, then no further questions are required.]
6. Does the patient require more than 4 units per day of the 1600mcg strength of oral fentanyl? Y N

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Comments: ____

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

____

Prescriber (Or Authorized) Signature and Date