



Prior Authorization Form

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

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 Fentora Post Limit (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)

Fentora

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