SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Fentanyl Orals

Drug Requested (select **one** from below)**:**

❑ **Fentora®** (fentanyl buccal tablets),	❑ **Lazanda®** (fentanyl nasal spray)
❑ **Subsys™** (fentanyl sublingual spray)	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: ______________________________

Member Sentara #: ______________________ **Date of Birth:** ____________

Prescriber Name: ______________________________

Prescriber Signature: ______________________ **Date:** ____________

Office Contact Name: ______________________________

Phone Number: ____________________ **Fax Number:** ____________________

DEA OR NPI #: ______________________________

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: ______________________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

Diagnosis: ____________________ **ICD Code, if applicable:** ____________________

Weight: ____________________ **Date:** ____________________

Recommended dosage: Therapy should always be initiated with the lowest strength available. This is 100 mcg for Fentora®, Lazanda® and Subsys™.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is ≥ 18 years of age.

AND

(Continued on next page)

❑ Member has breakthrough cancer pain and is opioid tolerant.

<u>AND</u>

❑ Member has failed a trial of oral transmucosal fentanyl citrate **(<u>requires a PA</u>).**

<u>AND</u>

❑ Member has failed a trial of Abstral® **(<u>fentanyl sublingual tablets requiring a PA</u>).**

<u>AND</u>

❑ Provider has checked information on this patient in the state's Prescription Monitoring Program database.

- **Date PMP database checked: ________________________________**

The database check <u>MUST</u> be within the <u>last 90 days</u>.

*****<u>Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.</u>*****

****<u>Previous therapies will be verified through pharmacy paid claims or submitted chart notes.</u>****