Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Fentanyl Citrate Transmucosal Lozenge - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Has the patient been previously approved for fentanyl citrate transmucosal lozenges?
If No, go to 4.

☐ Yes ☐ No

Q2. Has the prescriber attached an updated patient evaluation including the following documentation:
A) Assessment of pain severity and functional ability,
B) Progress towards achieving therapeutic goals,
C) Presence of adverse effects,
D) Plan of care including duration of treatment,
E) Assessment for possible aberrant drug-related behaviors, substance, use, and psychological issues?
[Note: Documentation is required for approval.]

☐ Yes ☐ No

Q3. Will the patient remain on around-the-clock opioids while receiving treatment with fentanyl citrate transmucosal lozenges?
If Yes, go to 10.

☐ Yes ☐ No

Q4. Is the prescriber a pain management specialist or an oncologist?

☐ Yes ☐ No

Q5. Is the patient 16 years of age or older?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Are both the patient and the prescriber enrolled in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access Program?
Must attach documentation of enrollment.

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of cancer?
[Note: Documentation is required for approval.]

☐ Yes ☐ No

Q8. Has the patient become tolerant to around-the-clock opioid therapy for persistent cancer pain?
[Note: Opioid tolerance is defined as patients taking at least 60 mg of oral morphine daily, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8 mg of oral hydromorphone daily, at least 25 mg of oral oxymorphone daily or an equianalgesic dose of another opioid daily for 1 week or longer.]

☐ Yes ☐ No

Q9. Will the patient remain on around-the-clock opioids while receiving treatment with fentanyl citrate transmucosal lozenges?

☐ Yes ☐ No

Q10. Additional Information:

Q11. Requested Duration:

☐ 6 Months

Prescriber Signature

Date

2022 Medicare Prior Authorization Request