Attention: ACTION REQUESTED
Prior Authorization DENIAL may occur unless complete information is provided

Reference: [PA#]

General Prior Authorization Form: Fentanyl

FAX COMPLETED FORM TO QHP PHARMACY DEPT. Fax # 877-817-0842

Coverage Criteria:

-Covered Uses: All medically accepted indications not otherwise excluded from Part D.
-Required Medical Information: Cancer pain: for the management of breakthrough cancer pain. At least a one week history of one of the following medications to demonstrate tolerance to opioids: morphine sulfate at doses of greater than or equal to 60 mg/day, fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, oxycodone at a dose of greater than or equal to 30 mg/day, oral hydromorphone at a dose of greater than or equal to 8 mg/day, oral oxymorphone at a dose of greater than or equal to 25 mg/day, an alternative opioid at an equianalgesic dose (eg, oral methadone greater than or equal to 20 mg/day). The patient is currently taking a long-acting opioid around the clock for cancer pain
-Prescriber Restrictions: Prescribed by or in consultation with an oncologist, pain specialist, hematologist, hospice care specialist, or palliative care specialist.
-Coverage Duration: 12 months

Member Information	Prescriber Information	
Patient Name:	Prescriber Name:	
Member ID#	NPI or DEA#:	
DOB:	Office Phone:	Office Fax:
Address:	Address:	
Home Phone:	Contact Person:	Prescriber Specialty:

Medication Information	Medical Information
Medication Requested (drug name, strength and route of administration):	Drug Allergies:
Medication Details (frequency, quantity):	Diagnosis:
Expected Length of Therapy:	Prescriber's Signature/Date:

Rationale for Prior Authorization

1. Please list other medications attempted for this patient:

Medication:	Reason therapy failed:	Length of therapy:
______________________	__________________________	________________________
______________________	__________________________	________________________
______________________	__________________________	________________________

2. Additional comments: ____
____

3. PLEASE INCLUDE RELEVANT MEDICAL RECORDS AND LAB REPORTS WITH YOUR REQUEST.

For Expedited Requests please call 1-877-233-7058
Our Formulary List is located at http://www.qualityhealthplansny.com

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Last Update 08/13/2015