**CAREFIRST**
**Actiq**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Actiq.

## Patient Information

**Patient Name:**

**Patient Phone:** ☐☐☐-☐☐☐-☐☐☐☐

**Patient ID:**

**Patient Group:**

**Patient DOB:** ☐☐/☐☐/☐☐☐☐

## Physician Information

**Physician Name**

**Physician Phone:** ☐☐☐-☐☐☐-☐☐☐☐

**Physician Fax:** ☐☐☐-☐☐☐-☐☐☐☐

**Physician Addr.:**

**City, St, Zip:**

## Drug Name (select from list of drugs shown)

Fentanyl Citrate Oral Transmucosal Lozenge  Actiq (fentanyl citrate oral transmucosal lozenge)

**Quantity:** _____ **Frequency:** _____ **Strength:** _____

**Route of Administration:** _____ **Expected Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____

## Please check the appropriate answer for each applicable question.

1. The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. Is the requested drug being prescribed for the management of breakthrough pain in a CANCER patient with underlying CANCER pain? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes or other documentation supporting a diagnosis of cancer-related pain AND list the type of cancer. For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED DIAGNOSIS. **Y** ☐ **N** ☐

2. Have chart notes or other documentation supporting a diagnosis of cancer-related pain AND the type of cancer been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

3. Is the patient currently receiving, and will continue to receive, around-the-clock opioid therapy for underlying CANCER pain? **Y** ☐ **N** ☐

4. The requested drug is intended only for use in opioid tolerant patients. Can the patient safely take the requested dose based on their current opioid use history? [Ensure that the patient can safely take the requested dose based on their current opioid use history. These drugs should be prescribed only by healthcare professionals who are knowledgeable about the use of opioids and how to mitigate the associated risks. Patients considered opioid tolerant are those who are taking, for one week or longer, around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg of transdermal fentanyl per hour, at least 30 mg of oral oxycodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg of oral oxymorphone per day, at least 60 mg of oral hydrocodone per day, or an equianalgesic dose of another opioid.] **Y** ☐ **N** ☐

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|---|---|---|---|
| 5. | Coverage is provided for up to 120 units per month. If additional quantities are needed, then additional questions are required. Is MORE than this quantity needed to manage the patient's pain? | **Y** ☐ | **N** ☐ |
| 6. | Is the patient's dose of a concomitant long-acting analgesic being increased? | **Y** ☐ | **N** ☐ |
| 7. | Are additional quantities of the requested drug needed for breakthrough pain because the dose of the patient's long-acting analgesic is unable to be increased? | **Y** ☐ | **N** ☐ |
| 8. | Does the patient's pain require use of MORE than 180 units per month? | **Y** ☐ | **N** ☐ |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

**Prescriber (Or Authorized) Signature and Date**