PA Request Criteria

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CAREFIRST - MD EXCHANGE 5T
Abstral

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 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Abstral.

Patient Name: _____ **Date:** 11/28/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)

Abstral (fentanyl citrate sublingual tablet)

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 who is currently receiving around-the-clock opioid therapy for underlying CANCER pain? If yes, then prescriber MUST submit chart notes or other documentation supporting a diagnosis of cancer-related pain AND list type of cancer _____ **Y** ☐ **N** ☐

   [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED DIAGNOSIS.]

2. Have chart notes or other documentation supporting a diagnosis of cancer-related pain been submitted to CVS Health? **Y** ☐ **N** ☐

3. Which drug is being requested? Please check the drug being requested.

   - Abstral 600 mcg or 800 mcg (if checked, then go to 4) ☐
   - Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg (if checked, then go to 6) ☐
   - Actiq (all strengths) (if checked, then go to 6) ☐
   - Fentora (all strengths) (if checked, then go to 6) ☐
   - Lazanda 100 mcg (if checked, then go to 7) ☐
   - Lazanda 300 mcg or 400 mcg (if checked, then go to 5) ☐
   - Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg (if checked, then go to 6) ☐
   - Subsys 1200 mcg, 1600 mcg (if checked, then go to 8) ☐

   [Note: Ensure that the patient can safely take the requested dose based on their history of opioid use.]

4. Coverage is provided for up to 120 units per month of Abstral 600 mcg, 800 mcg. Is MORE than this quantity needed to manage the patient's pain? **Y** ☐ **N** ☐

5. Coverage is provided for up to 240 sprays per month (i.e., 30 bottles per month) of Lazanda 300 mcg, 400 mcg. Is MORE than this quantity needed to manage the patient's pain? **Y** ☐ **N** ☐

6. Coverage is provided for up to 120 units per month of the following: A) Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg, B) Actiq (all strengths), C) Fentora (all strengths), D) Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg. If higher quantities are needed, then additional questions are required. Is MORE than this quantity needed to manage the patient's pain? **Y** ☐ **N** ☐
   [Note Subsys packaging: Supplied as 1 spray per blister for Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg.]

7. Coverage is provided for up to 240 sprays per month (i.e., 30 bottles per month) of Lazanda 100 mcg. If higher quantities are needed, then additional questions are required. Is MORE than this quantity needed to manage the patient's pain? **Y** ☐ **N** ☐

8. Coverage is provided for up to 240 sprays per month (i.e., 120 blisters per month) of Subsys 1200 mcg or 1600 mcg. If higher quantities are needed, then additional questions are required. Is MORE than this quantity needed to manage the patient's pain? **Y** ☐ **N** ☐
   [Note Subsys packaging: Supplied as 2 sprays per blister for Subsys 1200 mcg and 1600 mcg.]

9. Is the patient's dose of a concomitant long-acting analgesic being increased? **Y** ☐ **N** ☐

10. 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** ☐

11. Which drug is being requested? Please check the drug being requested.

   Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg (if checked, then go to 12) ☐

   Actiq (all strengths) (if checked, then go to 12) ☐

   Fentora (all strengths) (if checked, then go to 12) ☐

   Lazanda 100 mcg (if checked, then go to 13) ☐

   Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg (if checked, then go to 12) ☐

   Subsys 1200 mcg, 1600 mcg (if checked, then go to 14) ☐

   [Note: Ensure that the patient can safely take the requested dose based on their history of opioid use.]

12. Does the patient's pain require use of MORE than 180 units per month of any of the following: A) Abstral 100 mcg, 200 mcg, 300 mcg, 400 mcg, B) Actiq (all strengths), C) Fentora (all strengths), D) Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg? **Y** ☐ **N** ☐
   [Note Subsys packaging: Supplied as 1 spray per blister for Subsys 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg.]

13. Does the patient's pain require use of MORE than 360 sprays per month (i.e., 45 bottles per month) of Lazanda 100 mcg? **Y** ☐ **N** ☐

14. Does the patient's pain require use of MORE than 360 sprays per month (i.e., 180 blisters per month) of Subsys 1200 mcg or 1600 mcg? **Y** ☐ **N** ☐
   [Note Subsys packaging: Supplied as 2 sprays per blister for Subsys 1200 mcg and 1600 mcg.]

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

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit www.covermymeds.com/epa/caremark