BlueCross BlueShield
Federal Employee Program

ACTIQ
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Actiq

(oral transmucosal fentanyl citrate)

NOTE: Form must be completed in its **entirety** for processing

Please select strength:

❑200mcg ❑400mcg ❑600mcg ❑800mcg ❑1200mcg ❑1600mcg

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

How many units are being requested for 90 days? _____ unit(s) per 90 days

1. What is the patient's diagnosis?
   ❑Breakthrough cancer pain
   a. Location or type of cancer being treated: _____
   ❑Other diagnosis ***(please specify)***: _____
2. Is the patient currently on around the clock opioid analgesia for at least 1 week, excluding as needed or PRN dosing? ❑Yes ❑No
3. Is the patient taking one of the following listed therapies for at least 1 week or longer and therefore considered opioid tolerant: at least 60mg of oral morphine/day, at least 25mcg transdermal fentanyl/hr, at least 8mg oral hydromophone/day, at least 25mg oral oxymorphone/day, at least 30mg oral oxycodone/day, **OR** an equianalgesic dose of another opioid? ❑Yes ❑No*
   ***If NO**, did the patient require lower doses to achieve tolerance because of age or renal status? ❑Yes ❑No
4. Is the prescriber an oncologist or pain specialist who is knowledgeable of, and skilled in, the use of Schedule II opioids to treat cancer pain? ❑Yes ❑No
5. Are both the prescriber and the patient enrolled in the TIRF REMS program? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***