BlueCross BlueShield Federal Employee Program

FENTANYL POWDER 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					

Fentanyl Powder

(fentanyl citrate)

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

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

Please select the dosage form Fentanyl powder be compounded into:

❒**Inhaler** ❒**Nasal spray** ❒**Suppository** ❒**Buccal (film/mucous membrane patch)**
❒**Intrathecal (sterile solution)** ❒**Nebulizing solution** ❒**Tablet (oral/sublingual/capsule)**
❒**Lozenge/troche/lollipop** ❒**Sublingual spray** ❒**Topical (cream/gel/ointment/patch/solution)**
❒**Other dosage form *(please specify)***: _____

1. Will the patient be using the compounded Fentanyl product with another immediate release Fentanyl product? ❒Yes ❒No
2. Is the requested dosage form commercially available? ❒Yes ❒No
3. Is the requested dose **NOT** commercially available and does **NOT** exceed the FDA approved maximum strength for the equivalent commercially available product? ❒Yes ❒No
4. Does the prescriber agree to participate in the ***Opioid Analgesic REMS program and to monitor for abuse, misuse, addiction, and overdose and discontinue if necessary? ❒Yes ❒No

***Opioid Analgesic REMS*: **https://opioidanalgesicrems.com**

SECTION A: Please answer the following questions for ALL dosage forms EXCEPT intrathecal solution

5. What is the patient's diagnosis?
   - ❒Breakthrough cancer pain
     a. Location and/or type of cancer being treated: _____
   - ❒Other diagnosis ***(please specify)***: _____
6. Is the prescribing healthcare professional knowledgeable of, and skilled in, the use of Schedule II opioids to treat cancer pain? ❒Yes ❒No
7. Is this the **INITIATION** of compounded Fentanyl powder therapy? ***Please select answer below:***

   ❒**YES:** This is **INITIATION** of therapy, please answer the following questions:

   a. Is the patient already receiving **around the clock** opioid therapy for underlying persistent cancer pain? ❒Yes ❒No

   b. Has the patient been taking one of the following listed therapies for at least one 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 hydromorphone/day, at least 25mg oral oxymorphone/day, at least 30mg oral oxycodone/day, **OR** an equianalgesic dose of another opioid? ❒Yes ❒No*

   If NO, has the patient been taking lower dosages to achieve tolerance in a renal impaired or elderly patient? ❒Yes ❒No

   ❒**NO:** This is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

   a. Has the patient remained on **around-the-clock** opioid therapy? ❒Yes ❒No

SECTION B: Intrathecal Solution Use Only

5. Is the intrathecal solution being used for intraoperative and/or postoperative analgesia? ❒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.***