BlueCross BlueShield Federal Employee Program

ONSOLIS
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 cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

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

Onsolis

(fentanyl buccal soluble film)

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

Please select strength and indicate quantity:

❑ **200mcg*** ❑ **400mcg** ❑ **600mcg** ❑ **800mcg** ❑ **1200mcg**

How many units are being requested for a 90 day supply? _____ units per 90days

Initial PA MUST be for 200mcg even if patient is established on another fentanyl product

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

1. Select diagnosis for which Onsolis is being prescribed:
   - ❑ Breakthrough cancer pain: Specify location or type of cancer being treated: _____
   - ❑ Other diagnosis **(*please specify*)**: _____
2. Is the prescribing physician knowledgeable of, and skilled in, the use of Schedule II opioids to treat cancer pain? ❑Yes ❑No
3. Are both the physician and patient enrolled in the TIRF REMS Access program? ❑Yes ❑No
4. Is this **INITIATION** or **CONTINUATION** of Onsolis therapy? ***Please select answer below:***

   ❑ **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. Is the patient taking one of the following listed therapies and therefore considered opioid tolerant: at least 60mg oral morphine/day, at least 25mcg transdermal fentanyl/hr, at least 30mg of oral oxycodone daily, at least 8mg oral hydromorphone daily , or at least 25 mg oral oxymorphone daily **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

   ❑ **CONTINUATION (PA renewal)** of therapy, please answer the following question:

   a. Has the patient remained on around the clock opioid therapy? ❑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 info 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 PA request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***