Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Fentanyl Transmucosal IR Agents (TIRF) (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Fentanyl Transmucosal IR Agents (TIRF) (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Abstral (fentanyl sublingual tablets) Fentora (fentanyl buccal tablets) fentanyl citrate lozenges

Lazanda (fentanyl citrate nasal spray) Subsys (fentanyl sublingual spray)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 4.]

2. Has the patient had improvement in breakthrough cancer pain? Y N

   [If no, then no further questions.]

3. Is the patient continuing the use of a long-acting opioid around-the-clock while on treatment? Y N

[No further questions.]

4. Is the requested drug being prescribed by or in consultation with an oncologist or pain specialist? Y N

   [If no, then no further questions.]

5. Does the patient have the diagnosis of cancer? Y N

   [If no, then no further questions.]

6. Will treatment be used for breakthrough cancer pain? Y N

   [If no, then no further questions.]

7. Is the patient taking a long-acting opioid around-the-clock for treatment of cancer pain? Y N

   [If no, then no further questions.]

8. Is the patient considered to be opioid-tolerant, having received at least ONE WEEK of treatment on ONE of the following medications: A) Morphine sulfate at doses of at least 60 mg/day, B) Fentanyl transdermal patch at doses of at least 25 mcg/hour, C) Oxycodone at doses of at least 30 mg/day, D) Oral hydromorphone at doses of at least 8 mg/day, E) An alternative opioid at an equianalgesic dose for at least a week (e.g., oral methadone at doses of at least 20 mg/day)? Y N

   [If no, then no further questions.]

9. Is this request for generic fentanyl citrate lozenges? Y N

   [If no, then skip to question 11.]

10. Is the patient 16 years of age or older? Y N

    [No further questions.]

11. Has the patient experienced an inadequate response or intolerance to generic fentanyl citrate lozenges? Y N

    [If no, then no further questions.]

12. Is the patient 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date