



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Nasal and Oral Fentanyl Products Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
For states, such as GA and AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:					
Will the requested medication be used for the treatment of a terminal condition or associated symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "YES", please indicate the patient's estimated life expectancy:					
<input type="checkbox"/> Less than 6 months <input type="checkbox"/> Less than 24 months <input type="checkbox"/> Less than ____ months (please specify)					
Select the diagnosis below:					
Does the patient have a diagnosis of cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes to the above, is the requested medication used to manage breakthrough pain due to cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Select any of the following that the patient has at least a one week history of to demonstrate tolerance to opioids:					
<input type="checkbox"/> An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day)					
<input type="checkbox"/> Fentanyl transdermal patch at doses greater than or equal to 25 µg/hour					
<input type="checkbox"/> Morphine sulfate at doses of greater than or equal to 60 mg/day					
<input type="checkbox"/> Oral oxycodone at a dose of greater than or equal to 25 mg/day					
<input type="checkbox"/> Oral hydromorphone at a dose of greater than or equal to 8 mg/day					
<input type="checkbox"/> Oxycodone at a dose of greater than or equal to 30 mg/day					
Select the medications the patient has a failure, contraindication, or intolerance to:					
<input type="checkbox"/> Fentanyl lozenge					
<input type="checkbox"/> Hydromorphone immediate-release (IR)					
<input type="checkbox"/> Morphine sulfate IR					
<input type="checkbox"/> Oxycodone IR					
<input type="checkbox"/> Oxycodone IR					
Current treatment:					
Is the patient currently taking a long-acting opioid around the clock for cancer pain? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Nasal-OralFentanylProducts_Comm_2018Jan-W



Nasal and Oral Fentanyl Products Prior Authorization Request Form (Page 2 of 2)

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Prescriber specialty:

Is the requested medication prescribed by or in consultation with a hematologist, hospice care specialist, pain specialist, palliative care specialist, or oncologist? Yes No

Quantity limit requests:

What is the quantity being requested per DAY: _____

Select all of the following that have been maintained and documented in chart notes:

- A description of the nature and intensity of the pain
- An appropriate patient medical history and physical examination
- An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
- Appropriate dose escalation
- Ongoing, periodic review of the course of opioid therapy
- Verification that the risks and benefits of the use of the controlled substance have been discussed with the patient, significant other(s), and/or guardian

Chart documentation:

Will chart documentation be submitted to *OptumRx*[®] with this form, confirming the above information? Yes No

***Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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