Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Fentanyl Citrate Transmucosal Lozenge - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient been previously approved for fentanyl citrate transmucosal lozenges?

☐ Yes ☐ No

Q2. Have you attached an updated evaluation that includes the following documentation? a. Assessment of pain severity and functional ability; b. Progress towards achieving therapeutic goals; c. Presence of adverse effects; d. Plan of care including duration of treatment; e. Assessment for possible aberrant drug-related behaviors, substance use, and psychological issues

☐ Yes ☐ No

Q3. Will the patient remain on around-the-clock opioids while receiving treatment with fentanyl citrate transmucosal lozenges?

☐ Yes ☐ No

Q4. Is the prescriber either a pain management specialist or an oncologist?

☐ Yes ☐ No

Q5. Is the patient 16 years of age and older?

☐ Yes ☐ No

Q6. Are both the patient and the prescriber enrolled in the Transmucosal Immediate Release Fentanyl (TIRF) REMs Access Program? Please attach documentation of enrollment.

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of cancer? Please attach documentation.

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q8. Has the patient become tolerate to around-the-clock opioid therapy for persistent cancer pain? (Opioid tolerance is defined as patients taking at least 60 mg of oral morphine daily, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg oral oxycodone daily, at least 8 mg of oral hydromorphone daily, at least 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid daily for 1week or longer.)

☐ Yes ☐ No

Q9. Will the patient remain on around-the-clock opioids while receiving treatment with fentanyl citrate transmucosal lozenges?

☐ Yes ☐ No

Q10. Requested Duration:

☐ 6 months

Q11. Additional Information:

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request