CareFirst
The CareFirst BlueCross BlueShield family of health care plans

# Actiq ® – Prior Authorization Request

*Send completed form to: Case Review Unit CVS/caremark Fax: 888-836-0730*

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free 888-836-0730**. If you have questions regarding the prior authorization, please contact CVS/caremark at **800-294-5979.**

| **Patient Name:** | **Date**: |
|---|---|
| **Patient's ID:** | **Patient's Date of Birth:** |
| **Physician's Name:** | |
| **Specialty:** | **NPI#:** |
| **Physician Office Telephone:** | **Physician Office Fax:** |
| **Quantity:** | **Frequency:** |
| **Route of Administration:** | **Expected Length of Therapy:** |

1. Which drug is being prescribed?
   - ☐ Actiq (fentanyl citrate oral transmucosal lozenge
   - ☐ Fentanyl Citrate Oral transmucosal lozenge
   - ☐ Other ___________________

2. Does the patient have any of the following? ☐ Yes ☐ No
   - ☐ Significant respiratory depression
   - ☐ Known or suspected paralytic ileus

3. Is the drug being prescribed for the management of breakthrough pain in a cancer patient who is already receiving around-the-clock opioid therapy for underlying cancer pain? ☐ Yes ☐ No

4. Can the patient safely take the requested dose based on their current opioid use history? ☐ Yes ☐ No
   **Note: The TIRF (Transmucosal Immediate-Release Fentanyl) products (Abstral, Actiq, Fentora, Lazanda, and Subsys) are indicated for opioid- tolerant products. Patients considered opioid tolerant are those who are taking at least: 60 mg of oral morphine/day, 25 mcg of transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for a week or longer.]**

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.***

X_______________________________________________________________________________

**Prescriber or Authorized Signature** **Date: (mm/dd/yy)**

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