

OPTIMA HEALTH PLAN
Pharmacy Prior Authorization Request Form*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7516 or 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.

Drug Name: **Fentora® (fentanyl buccal tablets)**

- **Fentora (Fentanyl buccal tablets)** is only indicated for the management of breakthrough pain (BTP) in patients with cancer who are already receiving and who are tolerant to opioid therapy for their **underlying persistent cancer pain**.
- ◆ **Opioid tolerance is defined taking at least 60 mg morphine/day, 50 mcg transdermal fentanyl/hour or an equianalgesic dose of another opioid for a week or longer.**
- **Life-threatening hypoventilation can occur at any dose in a patient not taking chronic opiates. Fentora® is contraindicated in acute or postoperative pain management.**
- **Fentora® contains medication in an amount that could be fatal to a child.**

Please check all that apply: (all boxes must be checked to qualify for Fentora®)

Member has breakthrough cancer pain and is opioid tolerant.

AND

Member has failed a trial of Actiq®(oral transmucosal fentanyl citrate)

Patient _____

Member Number _____

Signed _____ Date _____

Physician Name _____ Phone Number _____

Fax Number _____

Pharmacy Name _____ Pharmacy Tel # _____

(If available)

*Approved by Pharmacy and Therapeutics Committee 2/15/07