UnitedHealthcare Community Plan

Fentanyl (Immediate Release) – Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- Have medical records been submitted demonstrating that medication use is for the management of pain associated with a cancer diagnosis? □ Yes □ No

- Is the medication being used for the management of breakthrough cancer pain? □ Yes □ No

- Does the patient have at least a one-week history of one of the following medications to demonstrate tolerance to opioids: □ Yes □ No (check which applies)

□ Morphine sulfate ≥ 60 mg/day
□ Fentanyl transdermal patch ≥ 25 mcg/hr
□ Oxycodone ≥ 30 mg/day
□ Oral hydromorphone ≥ 8 mg/day
□ Oral oxymorphone ≥ 25mg/day
□ An alternative opioid at an equianalgesic (e.g. oral methadone ≥ 20mg/day)

(If yes, complete Section D above with medication information: dose, dates of trial and reason for discontinuation)

- Is the patient currently taking a long-acting opioid around the clock for cancer pain? □ Yes □ No
If yes, list drug and dosing: _____

- Does the patient have history of failure, contraindication, or intolerance to fentanyl citrate lozenges (generic Actiq)? □ Yes □ No
(If yes, complete Section D above with medication information: dose, dates of trial and reason for discontinuation)

- Is the patient concurrently receiving an alternative transmucosal fentanyl transmucosal product? □ Yes □ No

- Is the patient currently receiving an alternative transmucosal fentanyl product AND the prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication? □ Yes □ No

Provider Signature: _____ Date: _____