

DURAGESIC (fentanyl transdermal patch)

PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. Is the participant 2 years of age or older? Y N
[If the answer to this question is no, then no further questions required.]
2. Does the participant have a diagnosis of cancer related pain? Y N
[If the answer to this question is yes, then skip to question 6.]
3. Does the participant have a diagnosis of persistent, moderate to severe chronic pain? Y N
4. Has the participant been assessed for clinical risks of opioid/substance abuse/ or addiction by one of the following tools, or another assessment tool for opioid abuse: CAGE questionnaire, Cyr-Wartman Screen, Skinner Trauma Screen, Screener and Opioid Assessment for Patients with Pain (SOAPP)? Y N
5. Does the participant require a dose greater than 300 micrograms per hour every 72 hours? Y N
6. Does the participant require continuous opioid analgesia? Y N

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7. Is the participant opioid-tolerant? (Participants are considered opioid-tolerant if they have been taking at least 25mcg transdermal fentanyl/hour, 60mg of oral morphine daily, 30mg of oral oxycodone daily, 8mg of oral hydromorphone daily, 25mg of oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer.) Y N
8. Does the participant require Duragesic / transdermal fentanyl more often than every 48 hours? Y N
9. Is the participant taking any cytochrome P450 3A4 inhibitors (e.g., ritonavir, ketoconazole, itraconazole, troleandomycin, clarithromycin, nelfinavir, nefazodone, amiodarone, amprenavir, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, grapefruit juice, or verapamil)? Y N
- [If the answer to this question is no, then no further questions are required.]
10. Will the participant be carefully monitored and will dosage adjustments be made if necessary? Y N

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date:
