PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D - Fentanyl Oral Transmuc & Lazanda

Phone: 800-728-7947 Fax back to: 866-880-4532

Scott & White Prescription Services 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 left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

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

Q1. Please select the diagnosis for which this drug is being prescribed.

☐ Breakthrough cancer pain

☐ Other (please specify)

Q2. Is the patient opioid tolerant (i.e. the patient has been taking doses that equal or exceed morphine 60 mg/day, transdermal fentanyl 25 mcg/hr, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for 1 week or longer)?

☐ Yes ☐ No

Q3. Additional Comments

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function