Updated: 08/2019
DMMA Approved: 08/2019

Request for Prior Authorization for Transmucosal Immediate Release Fentanyl Formulations
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Transmucosal Immediate Release Fentanyl Formulations require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Transmucosal Immediate Release Fentanyl Formulations Prior Authorization Criteria:
For all requests for Transmucosal Immediate Release Fentanyl Formulations all of the following criteria must be met:

- Member is within the FDA-approved age range for the product requested
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of breakthrough cancer pain and the following criteria is met:

- Must provide documentation of an active cancer diagnosis
- Member must be opioid tolerant. Opioid tolerance is defined as members taking at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, at least 60 mg of oral hydrocodone per day, or an equianalgesic dose of another opioid daily for a week or longer
- Member will remain on a long-acting opioid while taking an immediate release fentanyl product
- The recommended dose should not exceed four doses per day of immediate release fentanyl, regardless of formulation. If the member experiences more than 4 episodes of breakthrough cancer pain per day, the dose of the long-acting (maintenance) opioid should be re-evaluated.
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to two preferred short-acting opioid analgesics
- **Initial Duration of Approval:** 1 month
- **Reauthorization criteria**
    - Must provide documentation showing treatment with the requested medication has provided improvement in the member's condition.
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or

peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

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Immediate Release Fentanyl Formulations
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Is the medication being prescribed for breakthrough cancer pain in a member with an active cancer diagnosis?
☐ Yes ☐ No If **yes**, please provide cancer diagnosis: _____
Is the member opioid tolerant*? ☐ Yes ☐ No
Will the member remain on a long-acting opioid while receiving treatment with immediate release fentanyl? ☐ Yes ☐ No
*Opioid tolerance is defined as patients taking at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, at least 60 mg of oral hydrocodone per day, or an equianalgesic dose of another opioid daily for a week or longer.

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date

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