Health Options
Highmark Blue Cross Blue Shield Delaware

Prior Authorization Conditions for Fentanyl Transmucosal/Transbuccal/Sublingual
Website Form – www.highmarkhealthoptions.com
Submit request via Fax: 855-476-4158

All requests for fentanyl transmucosal/transbuccal/sublingual products require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Fentanyl trasmucosal/transbuccal/sublingual product Prior Authorization Criteria:

- Coverage may be provided when the following criteria is met:
  - Member is within the FDA-approved age range for the product requested; **AND**
  - Medication is being used for the management of breakthrough cancer pain in a member with an active cancer diagnosis; **AND**
  - 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; **AND**
  - Member has tried and failed or has a documented intolerance or contraindication to two preferred short-acting opioid analgesics; **AND**
  - Member will remain on a long-acting opioid while taking an immediate release fentanyl product; **AND**
  - 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.

- Initial authorization: 1 month to determine member tolerance to fentanyl
- Reauthorization will be granted for 6 months when the prescriber submits documentation that the medication is effective in treating the member's breakthrough cancer pain.

- 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.

References:

1. National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Adult Cancer Pain. Version 2.2017. May 2017.
2. Fentanyl. Micromedex Solutions. Truven Health Analytics, LLC. Accessed June 2017.
3. Fentanyl citrate. Micromedex Solutions. Truven Health Analytics, LLC. Accessed June 2017.
4. Abstral [package insert]. Solana Beach, CA: Sentynl Therapeutics, Inc.; December 2016.
5. Actiq [package insert]. North Wales, PA: Cephalon, Inc.; December 2016.
6. Fentora [package insert]. North Wales, PA: Cephalon, Inc.; December 2016.
7. Lazanda [package insert]. Newark, CA: Depomed, Inc.; March 2017.
8. Subsys [package insert]. Chandler, AZ: Insys Therapeutics, Inc.; December 2016.

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Fentanyl Transmucosal/Transbuccal/Sublingual
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Health Options Pharmacy Services. **FAX:** 1-855-476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251

PROVIDER INFORMATION	
Requesting Physician:	NPI:
Physician Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION	
Patient Name:	
Health Options ID:	DOB:

REQUESTED DRUG INFORMATION	
Medication:	Quantity dispensed (# of units):
Strength/Frequency:	Duration:

MEDICAL HISTORY

Diagnosis: ICD-10:

Is the medication being prescribed for breakthrough cancer pain in a member with an active cancer diagnosis?
☐ Yes ☐ No
If **yes**, please list cancer diagnosis:

Is the member opioid tolerant*? ☐ 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).

Will the member remain on a long-acting opioid while receiving treatment with immediate release fentanyl?
☐ Yes ☐ No

PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

REAUTHORIZATION
If this is a reauthorization request, please describe the member's response to therapy:

Prescribing Physician Signature	Date