Iowa Department of Human Services

**FAX Completed Form To**
1 (800) 574-2515

**Provider Help Desk**
1 (877) 776-1567

# Request for Prior Authorization
# FENTANYL, SHORT ACTING PRODUCTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

| IA Medicaid Member ID # | Patient name | DOB |
|---|---|---|
| Patient address | | |
| Provider NPI | Prescriber name | Phone |
| Prescriber address | | Fax |
| Pharmacy name | Address | Phone |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | |
| Pharmacy NPI | Pharmacy fax | NDC |

**Prior authorization is required for short acting fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. Short acting fentanyl products:**

- **Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain.**
- **Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.**

**PLEASE NOTE THERE IS A BLACK BOX WARNING FOR THIS PRODUCT**

**Non-Preferred**

☐ Abstral ☐ Fentora ☐ Onsolis
☐ Actiq ☐ Lazanda ☐ Subsys

| **Strength** | **Dosage Instructions** | **Quantity** | **Days Supply** |
|---|---|---|---|
| _______ | _____________________ | ________ | ________ |

**Diagnosis:**

☐ **Breakthrough Cancer Pain (no malignancies)**
☐ **Breakthrough Cancer Pain (with malignancies)**
☐ **Other (specify):**_______________________________________________

Prescriber Specialty:

☐ Oncologist
☐ Pain management specialist
☐ Other (**specify**):_______________________________________________

Current opioid therapy: Drug Name_______________________________ Strength__________

Dosage instructions____________________ Opioid duration of therapy: __________weeks/months/years **(circle)**

Additional relevant information:_______________________________________________

Possible drug interactions/conflicting drug therapies:_______________________________________________

***Attach lab results and other documentation as necessary.***

| Prescriber signature (Must match prescriber listed above.) | Date of submission |
|---|---|
| | |

***IMPORTANT NOTE:*** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*