

**Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Oral Transmucosal Fentanyl (Actiq® and Fentora®)
BCBSVT and TVHP Fax # (888)-255-1006**

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 Member ID#: _____ Date of Birth: _____
 Provider Name: _____ Provider Phone: _____
 Provider Fax: _____ PCP Name: _____

INDICATIONS FOR USE

	<u>YES</u>	<u>NO</u>
1. Patient is diagnosed with breakthrough cancer pain (with malignancies); AND	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient is already receiving (and is tolerant to) around-the-clock opioid therapy for the underlying persistent cancer pain (e.g., at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl/hr, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer).	<input type="checkbox"/>	<input type="checkbox"/>
3. Actiq® Requests: Patient is ≥ 16 years of age	<input type="checkbox"/>	<input type="checkbox"/>
4. Fentora® Requests: Patient is ≥ 18 years of age		
5. Patient has received and has failed at least TWO short acting as needed (PRN) opioid break through pain management trials.	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient on moderate/severe CYP-450 3A4 inhibitor therapy will be monitored regularly while on concomitant treatment with transmucosal fentanyl (moderate inhibitors: e.g., amprenavir, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, and verapamil); (strong inhibitors: e.g., ritonavir, ketoconazole, itraconazole, troleanomycin, clarithromycin, nelfinavir, and nefazodone).	<input type="checkbox"/>	<input type="checkbox"/>
7. Transmucosal fentanyl will not be used within 14 days of MAO Inhibitor therapy.	<input type="checkbox"/>	<input type="checkbox"/>
8. Patient has a known hypersensitivity to any component of the fentanyl transmucosal product (Actiq® or Fentora®).	<input type="checkbox"/>	<input type="checkbox"/>
9. Patient is opioid non-tolerant and/or opioid naïve.	<input type="checkbox"/>	<input type="checkbox"/>
10. Patient only has as needed (PRN) prior opioid exposure and is not currently on "around-the clock" opioid therapy.	<input type="checkbox"/>	<input type="checkbox"/>
11. Patient has acute or postoperative pain (including headache/migraine).	<input type="checkbox"/>	<input type="checkbox"/>
Prescription be dispensed at (circle one): Provider Office RESTAT Pharmacy		

ACTIQ® AND FENTORA® ARE NOT TO BE CONVERTED ON A MCG PER MCG BASIS FROM ONE DRUG TO THE OTHER. THESE AGENTS ARE NOT TO BE USED INTERCHANGABLY; FENTORA® IS NOT A GENERIC VERSION OF ACTIQ®.

**Initial approval will be for a 3-month period. Extension will be for 9-months.
Dispensed ONLY in 30-day supplies.**

Dose: _____ Frequency: _____ Duration of Therapy: _____

PREScriBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

