

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR FENTANYL MUCOSAL AGENTS**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents Completion Instructions, F-00281A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.space for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Does the member have cancer that is causing persistent pain?

Yes

No

15. Is the member tolerant to around-the-clock opioid therapy for his or her underlying, persistent cancer pain?

Yes

No

16. Is the member currently taking a long-acting opioid analgesic drug(s)?

Yes

No

If yes, list the long-acting opioid analgesic drug(s) and dose(s) the member is currently taking in the space provided.

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DT-PA093-093

SECTION III — CLINICAL INFORMATION (Continued)

17. Does the member experience breakthrough cancer pain that is not relieved by other short-acting opioid analgesic drugs? Yes No

If yes, list the short-acting opioid analgesic drug(s) and dose(s) the member has previously taken in the space provided.

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF FENTANYL CITRATE ORAL TRANSMUCOSAL LOZENGES

18. Has the member previously taken fentanyl citrate oral transmucosal lozenges? Yes No

19. Has the member taken fentanyl lozenges for breakthrough cancer pain and experienced an unsatisfactory therapeutic response? Yes No

If yes, indicate the approximate dates fentanyl lozenges were taken in the space provided.

20. Does the member have a medical condition(s) that prevents him or her from taking fentanyl lozenges? Yes No

If yes, list the medical condition(s) in the space provided.

21. SIGNATURE — Prescriber

22. Date Signed

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

23. National Drug Code (11 Digits)

24. Days' Supply Requested (Up to 183 Days)

25. NPI

26. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

27. Place of Service

28. Assigned PA Number

29. Grant Date

30. Expiration Date

31. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

32. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.
