Catamaran Prior Authorization Department
Phone: 866-235-3062
Fax: 866-391-7222

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone - -	Fax - -

Member Information

Last Name:	First Name
Member ID Number	DOB: - -

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Abstral, Fentora, Lazanda, Onsolis & Subsys (fentanyl) Prior Authorization Criteria

Initial Therapy Please complete all applicable questions		
1. Please document ICD-9 code:_____		
2. Is the patient 18 years of age or older?	Y	N
3. Does the patient have a diagnosis of cancer and use of the medication is for breakthrough cancer pain?	Y	N
4. Is the patient opioid tolerant and taking at least 60 mg morphine/day, at least 25 mcg transdermal fentanyl/hour, at least 30mg of oxycodone daily, at least 8mg oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer (see table 1)?	Y	N
5. Has the patient tried other formulary short-acting strong narcotic analgesic alternatives (other than fentanyl) and the medication was ineffective, not tolerated, or contraindicated? *Note: Examples of short-acting strong narcotics include, but are not limited to, concentrated morphine oral solution, oxycodone or hydromorphone.*	Y	N
6. Is the physician enrolled in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access Program?	Y	N
7. Which of the following contraindications or exclusions (if any) to the use of therapy does the patient have? **(Please circle)** • Use in the management of acute or postoperative pain, including headache/migraine, dental pain, or use in the emergency room • Use in opioid non-tolerant patients • None		

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Renewal Therapy Please complete all applicable questions		
1. Please document ICD-9 code: _____		
2. Is the patient 18 years of age or older?	Y	N
3. Has the patient experienced an objective response to therapy?	Y	N

Comments: _____

Information given on this form is accurate as of this date.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 800-626-0072.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).