



Office use only: Reviewed by: \_\_\_\_\_  
Review date: \_\_\_\_\_ Approved Denied

### Prior Authorization Form

**Actiq (fentanyl citrate)**

**ONLY COMPLETED FORMS WILL BE RECEIVED**

Dosage: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Provider Specialty: \_\_\_\_\_

Office Fax: \_\_\_\_\_

**1. Coverage criteria:**

- For patients with pain due to a malignancy (i.e. cancer) diagnosis ONLY and
- For patients to manage breakthrough cancer pain who are tolerant to opioid therapy

Actiq is NOT covered for the management of acute or postoperative pain or for patients not taking chronic opiates or not tolerant to opioid therapy.

**2. Is patient being treated for breakthrough pain due to a malignant diagnosis?**

Yes                       No

**3. Current opioid therapy (fentanyl, oxycodone, morphine sulfate, etc.)**

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ Date(s) used: \_\_\_\_\_

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ Date(s) used: \_\_\_\_\_

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ Date(s) used: \_\_\_\_\_

**Please attach any supporting clinical information that may be useful in the review of this prior authorization.**

**I attest with my signature that I am prescribing Actiq in accordance with published FDA guidelines.**

\_\_\_\_\_  
**Authorizing Physician**

\_\_\_\_\_  
**Date**

**Fax completed form to (706) 549-8004. Your office will receive a response via fax.**