

Drug Coverage Review Request

Actiq/Fentora/Onsolis



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PRESCRIBER

MD First Name _____
MD Last Name _____
Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
DEA number (optional) _____

PATIENT

Cardholder ID # _____
Patient Last Name _____
Patient First Name _____
Date of Birth _____
Address _____
City _____
State _____
Zip Code _____
Phone _____

Medco manages the prescription drug benefit for your patient on behalf of his/her plan sponsor. Your patient's prescription drug benefit has a preferred drug list to help keep benefits affordable, and certain medications require a review for determination of coverage. The medication that you have prescribed requires a coverage review. To request consideration for coverage of the non-preferred medication, please complete the following questions and then fax this form to the toll-free number shown below. Upon receipt of the completed form, prescription benefit coverage for the non-preferred medication will be decided.

SECTION A Please answer the following questions

- Yes No Is the requested drug being prescribed for the MANAGEMENT of breakthrough pain?
- Yes No Have other oral immediate-release narcotics been tried?
- Yes No If **NO** to the **previous** question, is the patient able to receive other oral immediate-release narcotics?
- Yes No If other oral immediate-release narcotics have been tried, has the patient experienced an **INADEQUATE RESPONSE** to the use of these medications?

Note: This medication is indicated only for the management of breakthrough pain in patients who are already receiving and are tolerant to narcotic therapy for their underlying persistent pain.

- Yes No Is the patient **CURRENTLY RECEIVING** a **LONG-ACTING** narcotic analgesic [for example, methadone, sustained-release morphine, oxycodone controlled-release tablets (*Oxycontin*[®]), or fentanyl transdermal system (*Duragesic*[®])] for treatment of chronic pain?
- Yes No If **Yes** to **previous** question, is the patient **TOLERANT** to a **LONG-ACTING** narcotic analgesic?

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET



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