COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Elixir Oral Fentanyl-15 STD/SELECT NF-PA-QL

Phone: 800-361-4542 Fax back to: 866-414-3453

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Please note that Elixir will process the request as written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is request for initial or continuing therapy?

☐ Initial ☐ Continuing Therapy

Q2. For CONTINUING THERAPY, please indicate Start Date (MM/YY):

Q3. Please indicate the patient's diagnosis below:

☐ Breakthrough cancer pain ☐ Other

Q4. If the diagnosis is OTHER, please specify below:

Q5. Please indicate the age of the patient below:

☐ 0 to 15 years old ☐ 16-17 years old ☐ 18 years or older

Q6. Is the patient opioid tolerant? (Opioid-tolerant patients are those requiring around-the-clock pain management consisting of daily doses of at least morphine 60 mg orally, fentanyl transdermal patch 25 mcg/hr, oxycodone 30 mg orally, hydromorphone 8 mg orally, or daily use of an equianalgesic dose of another opioid for a week or longer).

☐ Yes ☐ No

Q7. Is the patient currently on around-the-clock opioid therapy for cancer related pain?

☐ Yes ☐ No

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Q8. Has the patient tried/failed/intolerant to fentanyl lozenge?

☐ Yes
☐ No
☐ N/A - request is for fentanyl lozenge

Q9. If the patient has NOT tried fentanyl lozenge, is there a reason these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

Q10. Submission of chart notes with a documentation that the requested medication is being used for active cancer related pain is required, has this documentation been provided?

☐ Yes ☐ No

Q11. Was the requested medication prescribed by or in consultation with a pain management specialist or oncologist?

☐ Yes ☐ No

Q12. Does the patient have any of the following EXCLUSIONS/CONTRAINDICATIONS to the requested drug? (Check all that apply):

☐ Hypersensitivity to fentanyl or any component of the formulation
☐ Use in the management of acute or postoperative pain (including headache, migraine, dental pain, and acute pain treated in an emergency room setting)
☐ Use in patients who are not opioid tolerant
☐ Use in patients with acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment
☐ Known or suspected gastrointestinal obstruction (including paralytic ileus)
☐ None of the above

Q13. For renewal, please check all that apply:

☐ Chart notes with documentation that the requested medication is being used for active cancer related pain have been submitted
☐ Patient continues to be on around the clock opioid therapy for cancer related pain
☐ None of the above

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

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