FLORIDA MEDICAID PRIOR AUTHORIZATION

Abstral®/Actiq®/Fentora®/Lazanda®/Onsolis®/Subsys®

(fentanyl sublingual tablet / oral transmucosal lozenge / buccal tablet / nasal spray / buccal soluble film / sublingual spray)

Maximum Length of Approval = Three Months

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber's Phone Number - -

Prescriber's Fax Number - -

1. Is the patient currently receiving a short acting and long acting opioid analgesic on a routine basis?

   ☐ Yes ☐ No

2. Current opioid therapy: (must provide progress notes or medical records for verification of history and therapeutic outcomes of trials)

   Drug: ______________ ; Dose: ____________; Start & End dates:___________ ___________; Outcome: _________________

   Drug: ______________ ; Dose: ____________; Start & End dates:___________ ___________; Outcome: _________________

   Drug: ______________ ; Dose: ____________; Start & End dates:___________ ___________; Outcome: _________________

   Comments:

3. Does patient have an existing cancer diagnosis?

   ☐ Yes ☐ No

4. Is the prescribing physician's specialty an oncologist or pain management related to oncology?

   ☐ Yes ☐ No

5. Has restricted drug distribution program enrollment been completed? (documentation verifying enrollment must be submitted)

   ☐ Yes ☐ No

Prescriber's Signature: ____ **Date:** ___________________________

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to:
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

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