Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Oral Fentanyl
(Actiq, Fentanyl Lozenge, Fentora, Lazanda, Subsys)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (*please specify name, strength, and dosing schedule)*

☐ Actiq ☐ fentanyl lozenge ☐ Fentora ☐ Lazanda ☐ Subsys

Strength & Directions for use: Quantity per month requested:

Expected duration of therapy: ICD10:

Has your patient been titrated to the requested dose? Yes ☐ No ☐
(if yes) What previous doses of the requested medication has your patient tried?

(if yes) Please explain your patient's current treatment plan (include target dose and titration plan).

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

Is the medication being prescribed for breakthrough cancer pain? Yes ☐ No ☐
(if yes) What is the cancer diagnosis?
(if no) What is the diagnosis related to use?

Is the patient currently on around-the-clock dosing of opioid therapy (for example, long-acting opioids)? Yes ☐ No ☐
(if yes) Please provide the medication names:

Will your patient continue around-the-clock opioid therapy while on the requested drug? Yes ☐ No ☐

Does your patient have documented failure/inadequate response, intolerance, inability to use or individual is not a candidate for any of the following? (check all that apply)
☐ Actiq ☐ fentanyl lozenge ☐ Fentora ☐ Lazanda ☐ Subsys

Please include drug name and strength, date(s) taken or and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. If unable to use listed alternatives, please explain:

Additional Pertinent Information: (*please include clinical reasons for drug, relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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