

**ORAL FENTANYL
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM**



**BlueCross BlueShield
of Illinois**

ONLY the prescriber may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbsil.com

Today's Date: _____

PATIENT INFORMATION

| | | | |
|-----------------------|------------------|--------------------|-------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
| Patient Address: | City, State, Zip | Patient Telephone: | |

INSURANCE INFORMATION

| | |
|-----------------|---------------|
| BCBS ID Number: | Group Number: |
|-----------------|---------------|

PHYSICIAN/CLINIC INFORMATION

| | | | |
|-------------------|-----------------|---------------|---------------|
| Prescriber Name: | Physician NPI#: | Specialty: | Contact Name: |
| Clinic Name: | Clinic Address: | | |
| City, State, Zip: | Phone #: | Secure Fax #: | |

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

| | |
|--|---------------------|
| Patient's Diagnosis: | |
| Medication Requested: | Strength: |
| Dosing Schedule: | Quantity per Month: |
| <p>1. Is the patient currently treated with the requested medication?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, when was the treatment with the requested medication started? _____</p> <p>2. Can the patient's dose of fentanyl oral be accomplished with a lesser quantity of a higher strength (e.g. 8 x 100 mcg could be accommodated with 4 x 200 mcg)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is the patient currently treated with long-acting opioid medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list drug(s), dose(s) and schedule(s) _____</p> <p>4. Can the dose of the long-acting opioid medication be adjusted to control breakthrough pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Please list all medications the patient has previously tried and failed for treatment of chronic pain. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____</p> <p>6. Please list all other reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____</p> | |

Please fax or mail this form to:
Blue Cross and Blue Shield of Illinois
c/o Prime Therapeutics LLC, Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130

Phone: 800.285.9426

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