Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Oral and Intranasal Fentanyl Citrate Products (Actiq, Fentora, Onsolis, Abstral, Lazanda, Subsys)

Medical Necessity Request

1. Please indicate if the member has any of the following contraindications:
   - □ Management of acute or post-operative pain, including headache/migraine and dental pain
   - □ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment
   - □ Known or suspected gastrointestinal obstruction including paralytic ileus
   - □ NONE

2. Is the member being managed by an Oncologist or Pain Management specialist? **Yes or No**

3. What is the diagnosis?
   - □ **Cancer**
     a. Does member have breakthrough pain associated with cancer? **Yes** or **No**
     b. Is the member currently receiving around-the-clock opioid therapy (e.g., OxyContin, Morphine sulfate extended release, Fentanyl patch, etc) for their underlying persistent cancer pain?
        □ **No**
        □ **Yes** - Please provide the name, dosage, directions, and quantity of the opioid(s) the member has most recently received and the date last received.

Drug Name	Strength	Directions	Quantity	Date last received

     c. Will member continue to receive around-the-clock opioid therapy? **Yes** or **No**

   - □ **Other**: _____
     a. Is the member already receiving opioid therapy (e.g., Oxycodone/APAP, hydrocodone, Oxycontin, Morphine, etc)?
        □ **No**
        □ **Yes** - Please provide the name, dosage, directions, and quantity of the opioid(s) the member has most recently received and the date last received.

Drug Name	Strength	Directions	Quantity	Date last received

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**