

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Fentanyl Transdermal System (Duragesic) – Medical Necessity Request
*****Please complete page 1 and 2 for New/Initial requests*****

Contraindication Information (please indicate if the member has any of the following contraindications):

- Needs opioid pain relief for a short period of time
- Receiving the Duragesic patch for post-operative pain
- Acute or Intermittent pain
- Known or suspected gastrointestinal obstruction, including paralytic ileus
- Significant respiratory depression
- Acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment
- NONE

General Information

1. What is the diagnosis?
 - Pain
 - Other: _____
2. Is the pain persistent? **Yes or No**
3. Is the pain chronic? **Yes or No**
4. What is the pain severity?
 - Mild Moderate Severe
5. Is the member's pain severe enough to require daily around-the-clock, long-term opioid treatment? **Yes or No**
6. Is the member currently or will the member be on any other long-acting opioid pain controller together with the Fentanyl patch? (i.e. OxyContin, Avinza, MS Contin, Kadian, Oramorph, Duragesic/Fentanyl, Opana ER, Butrans) **Yes or No**
 - If yes, which long-acting opioid pain controller(s) will the member be receiving concurrently?

 - What is the clinical reason why the member is receiving more than one long-acting opioid pain controller?

7. Please document any long-acting opioids that have recently been discontinued or will be discontinued if fentanyl is approved (include date drug was discontinued)?

8. Is the member already receiving opioid therapy? (NOTE: Examples of opioids are OxyContin, Avinza, MS Contin, Kadian, Oramorph, Duragesic/Fentanyl, Opana, Percocet, or Vicodin) **Yes or No**
 - What opioid therapy is the member currently receiving and when was therapy last received? (dose, frequency, day supply, and date of last fill)

9. Can member try an alternative treatments (such as non-opioid analgesics or immediate-release opioids)? **Yes or No**
 - If Yes, Please call the medication prescription to the member's pharmacy
 - If No, Please provide clinical reason why _____

Physician office's signature* _____ Print Name _____

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

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10. How often will the Duragesic patch be applied? **every 72 hours** Other: _____

every 48 hours:

- Has the member tried an every 72-hours regimen?

Yes: Was adequate pain control was achieved using a 72-hour regimen at the requested strength?

Yes: Please provide the reason for requesting an every 48 hour regimen if adequate pain control was achieved using a 72-hour regimen.

 No

No: Can the member try an every 72 hours regimen?

Yes

No: Please provide the clinical reason why the member cannot try an every 72 hour regimen. _____

Physician office's signature* _____ Print Name _____

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****Complete page 3 only for Subsequent/Renewal requests****

1. Is the dose being increased, decreased or remaining the same?

Increased

- What additional opioid medication(s) is the member taking that necessitates the dose increase? Include drug name, strength, directions, day supply, and date of last fill. (NOTE: Examples of opioids are OxyContin, Avinza, MS Contin, Kadian, Oramorph, Duragesic/Fentanyl, Opana, Percocet, Dilaudid, Vicodin, etc.)

- What was the previous dose of Fentanyl and when was it last filled?

- Will the previous dose be discontinued? **Yes or No**

Decreased

- What was the previous dose of Fentanyl and when was it last filled?

- Will the previous dose be discontinued? **Yes or No**

Remaining the same

2. Is the member currently or will the member be on any other long-acting opioid pain controller? (i.e. OxyContin, Avinza, MS Contin, Kadian, Oramorph, Duragesic/Fentanyl, Opana ER, Butrans) **Yes or No**

a. If yes, which long-acting opioid pain controller(s) will the member be receiving concurrently?

b. What is the clinical reason why the member is receiving more than one long-acting opioid pain controller?

3. How often will the Duragesic patch be applied? (i.e., every 48 hours, every 72 hours, etc)

every 48 hours every 72 hours Other: _____

4. Has the member experienced improvement in pain and function? **Yes or No**

a. If No, please provide documentation outlining prescriber's plan (e.g. taper medication with intention to discontinue treatment, change in drug therapy or dose, maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate, and/or consult a pain management specialist).

Physician office's signature* _____ Print Name _____

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