ProCare Rx

Lazanda® fentanyl nasal spray

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Lazanda® fentanyl nasal spray. Based on recent clinical information, we require more information before this prescription can be paid by the patient's pharmacy benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:	Plan Name/Plan ID:		
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:	

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply) *For Re-Authorization, please re-document.*

1. Is this for the management of breakthrough pain in cancer patients 18 years of age or older who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain? Please provide documentation of cancer diagnosis. YES NO

2. A. Patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting? YES NO

   OR

   B. Patient is unable to take two other short-acting narcotics (e.g., oxycodone, morphine sulfate, hydromorphone, etc.) secondary to allergy or severe adverse events? YES NO

3. Patient is on or will be on a long-acting narcotic (e.g., Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (e.g., morphine sulfate, hydromorphone, fentanyl citrate)? YES NO

   Please document: _____

4. Patient has had an intolerance to, or treatment failure of, Actiq (fentanyl citrate lollipops)? YES NO

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.