



Fax completed form to Navitus at: 855-668-8553  
For questions, please call: 877-908-6023

### TEXAS MEDICAID

### Drug Prior Authorization

### Fentanyl Agents: buccal fentanyl citrate (FENTORA)

#### Request Information (required)

This request is:

- Expedited\* (Urgent)
- Standard (Non-Urgent)

\*Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

#### Member Information (required)

#### Prescriber Information (required)

Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

#### Please fill out the following information:

- Medication Requested (Name):  
(Go to #2)

Drug Prior Authorization

Fentanyl Agents: buccal fentanyl citrate (FENTORA)

2. Quantity Requested:  
(Go to #3)

3. Dose Requested (Strength):  
(Go to #4)

4. Dosing Instructions:  
(Go to #5)

**Required Criteria**

5. Provide primary diagnosis including ICD-10 code(s):  
(Go to #6)

6. Please indicate the requested drug's formulary status: \*(Formulary available at [www.txvendordrug.com](http://www.txvendordrug.com))

Non-Preferred Drug (NPD or NAP)

(Go to #7)

Preferred Drug (PDL)

(Go to #10)

No Status, Drug is not in a Market Basket

(Go to #10)

N/A as this request is for a CHIP/PERINATE member

(Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a six (6) day treatment trial with at least one (1) preferred agent in the last 180 days?

Yes

(Go to #10)

No

(Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

Yes

(Go to #10)

No

(Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes

(Go to #10)

No (Deny)

(Go to #10)

### Opioid Policy Criteria

10. Does the member have a diagnosis of ONE (1) of the following in the last 365 days?

- Cancer
- Hospice Care
- Palliative Care
- Sickle Cell

Yes

(Go to #16)

No

(Go to #11)

11. Does the member have a total of less than or equal to ( $\leq$ ) seven (7) days supply of opiates in the last 60 days?

Yes

(Go to #12)

No

(Go to #15)

12. Is the days supply of the requested medication greater than ( $>$ ) ten (10) days?

Yes (Deny)

(Go to #13)

No

(Go to #15)

13. Is the request for a long-acting opioid agent?

Yes (Deny)

(Go to #14)

No

(Go to #14)

14. Is the incoming request greater than (>) 90 morphine milligram equivalents (MME)?

Yes (Deny)  
(Go to #16)

No  
(Go to #16)

15. Does the member's total opiate intake exceed 90 morphine milligram equivalents (MME) per day?

Yes (Deny)  
(Go to #16)

No  
(Go to #16)

16. Please provide the drug names, strengths, and dosing instructions of ALL opioid products the member is currently taking:  
(Go to #17)

Clinical Criteria (required)

17. Is the member greater than or equal to ( $\geq$ ) 18 years of age?

Yes  
(Go to #18)

No (Deny)  
(Go to #18)

18. Does the member have a diagnosis of malignant cancer in the last 730 days?

Yes  
(Go to #20)

No  
(Go to #19)

19. Does the member have a history of an antineoplastic agent in the last 365 days?

Yes

(Go to #20)

No (Deny)

(Go to #20)

20. Does the member have a claim for a monoamine oxidase inhibitor (MAOI) or CYP3A4 inhibitor in the last 30 days?

Examples of MAOIs include: AZILECT, linezolid (ZYVOX), MARPLAN, phenelzine (NARDIL), selegiline (EMSAM, ZELAPAR), and tranylcypromine (PARNATE).

Examples of CYP3A4 inhibitors include: aprepitant (EMEND), AKYNZEO, BUNAVAIL/SUBOXONE, clarithromycin, COPIKTRA, CRESEMBA, diltiazem (CARDIZEM, CARDIZEM CD, CARTIA XT, DILT XR, MATZIM LA, TAZTIA XT, TIAZAC ER), erythromycin, fluconazole (DIFLUCAN), GLEEVEC, itraconazole (SPORANOX, TOLSURA), KETEK, ketoconazole, KISQALI, KORLYM, MULTAQ, nefazodone, NOXAFIL, PREVYMIS, TASIGNA, TECHNIVIE, verapamil (CALAN, VERELAN), VICTRELIS, VIEKIRA, voriconazole (VFEND), ZYDELIG, and certain HIV treatments (e.g. atazanavir (REYATAZ), CRIXIVAN, EVOTAZ, GENVOYA, INVIRASE, KALETRA, fosamprenavir (LEXIVA), PREZCOBIX, PREZISTA, ritonavir (NORVIR), VIRACEPT, STRIBILD, SYMTUZA, TYBOST, and VIRACEPT).

Yes (Deny)

(Go to #21)

No

(Go to #21)

21. Does the member have at least 12 days supply of opioid therapy in the last 14 days?

Yes

(Go to #22)

No (Deny)

(Go to #22)

22. Does the member have a history of buccal fentanyl in the last 35 days?

Yes

(Go to #29)

No

(Go to #23)

23. Does the member have a history of opioid tolerance with defined oral morphine, transdermal fentanyl, oxycodone, hydromorphone, OR oxymorphone therapy in the last 30 days?

Yes

(Go to #24)

No (Deny)

(Go to #24)

24. Is the request for buccal fentanyl (FENTORA) 100mcg?

Yes

(Go to #29)

No

(Go to #25)

25. Is the request for buccal fentanyl (FENTORA) 200mcg?

Yes

(Go to #26)

No

(Go to #27)

26. Does the member have a claim for ACTIQ 600, 800, 1200 or 1600mcg in the last 35 days?

Yes

(Go to #29)

No (Deny)

(Go to #27)

27. Is the request for buccal fentanyl (FENTORA) 400mcg?

Yes

(Go to #28)

No (Deny)

(Go to #28)

28. Does the member have a history of ACTIQ 1200 or 1600mcg in the last 35 days?

Yes

(Go to #29)

No (Deny)

(Go to #29)

29. Is the request for less than or equal to ( $\leq$ ) four (4) units/day?

Yes

(Go to #30)

No (Deny)

(Go to #30)

30. Does the member have a total of less than or equal to ( $\leq$ ) seven (7) days supply of opiates in the last 60 days?

Yes (Approve - 1 x for incoming prescription) (opioid naïve)

(Go to #31)

No (Approve 180 days) (opioid experienced)

(Go to #31)

**Additional Information**

31. Please provide any additional information we should consider (or attach any supporting documents):  
(END)

**Submission Information (required)**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\* PLEASE FAX COMPLETED FORM TO: 855-668-8553 \*\***



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If criteria not met, submit chart documentation with form citing complex medical circumstances.

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