Health New England
Medication Request Form (MRF)
Actiq® (Fentanyl Lozenge), fentanyl and Fentora ® buccal tablets

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Actiq®, fentanyl, and Fentora®. Please complete this form and fax to MedMetrics Health Partners at **(800) 550-9246**. If you have any questions regarding this process, please contact MedMetrics clinical call center at **(866) 209-1057**.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	**Physician Name:** **Specialty:**
	NPI #:
Patient HNE ID#:	**HNE Provider #:**
Patient Date of Birth:	**DEA #:**
Allergies:	**Area Code and Telephone #:** ( ) -
Diagnosis:	**Area Code and Fax #:** ( ) -

Drug Information		
Requested Drug / Strength: Actiq ® fentanyl Fentora ®		
Dose, directions and length of treatment (please be specific):	**Quantity (4 per day; 120 per 30 days max.):**	**Refills:**
Physician signature:	**Date:**	

Indication:

☐ Management of breakthrough cancer pain.
☐ Other (please describe):____

Documentation of Medical Criteria:

☐ Patient is currently receiving **around the clock** opioid pain medication with oral doses equal to or greater than the following: (will be verified by on-line claim history).
Codeine 200mg/day; Fentanyl Transdermal 50mcg/hr; Hydrocodone (Vicodin, Lortab, etc.)60mg/day; Hydromorphone 7.5mg/day; Levorphanol 4mg/day; Meperidine 300mg/day; Morphine 60mg/day; or Oxycodone 30mg/day.

Other Pertinent History (relative or pertaining to this request):

Effective date: 1/1/03 (date of last review 5/12/2009)