

Oral Fentanyl Products

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet	Date: ____/____/____
To: <u>Wellmark Pharmacy Services</u>	From (Prescriber's Name): _____
Fax Number: <u>(866) 884-4345</u>	Prescriber's DEA Number: _____
Phone Number: <u>(800) 600-8065</u>	Prescriber's Phone Number: _____
Prescriber's Specialty: _____	Prescriber's Fax Number: _____
Prescriber's Office Address: _____	
Street	Suite # City State Zip
Patient Name: _____	
Patient ID: _____	Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Is the medication being prescribed for breakthrough cancer pain with malignancies? Yes No

2. Please provide the diagnosis this therapy has been prescribed for: _____

ICD-9 Code: _____

3. Drug Requested: Abstral Actiq Fentora Onsolis

Drug Strength: _____mcg Quantity/30 days: _____units

Directions: _____

Printed Name

Signature

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.