



FLORIDA MEDICAID PRIOR AUTHORIZATION
Abstral®/Actiq®/Fentora®/Lazanda®/Onsolis®/Subsys®

(fentanyl sublingual tablet / oral transmucosal lozenge / buccal tablet / nasal spray / buccal soluble film / sublingual spray)

Maximum Length of Approval = Three Months

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber's Phone Number

Grid for Prescriber's Phone Number

Prescriber's Fax Number

Grid for Prescriber's Fax Number

- 1. Is the patient currently receiving a short acting and long acting opioid analgesic on a routine basis?
2. Current opioid therapy: (must provide progress notes or medical records for verification of history and therapeutic outcomes of trials)
Drug: ; Dose: ; Start & End dates: ; Outcome:
Drug: ; Dose: ; Start & End dates: ; Outcome:
Drug: ; Dose: ; Start & End dates: ; Outcome:

Comments:

Large empty box for comments

- 3. Does patient have an existing cancer diagnosis?
4. Is the prescribing physician's specialty an oncologist or pain management related to oncology?
5. Has restricted drug distribution program enrollment been completed? (documentation verifying enrollment must be submitted)

Prescriber's Signature: _____ Date: _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-800-310-6826

02.01.2025

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