

Ticket #: \_\_\_\_\_ Request Date: \_\_\_\_\_ Request Time: \_\_\_\_\_

**PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM**

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

<b>A. Member Information</b>			
Patient Name:		Plan Name/Plan ID:	
Patient ID:		Patient Date of Birth:	Patient Contact Phone #:
<b>B. Physician Information</b>			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Directions (SIG):	QTY and Days Supply:	NDC#:
<b>C. Pharmacy Information</b>			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
<b>D. Clinical Information (Please fill out the following information: circle all that apply)</b>			
1. Is the patient currently receiving a short acting and long acting opioid analgesic on a routine basis?		YES	NO
2. Current opioid therapy: (Must provide progress notes or medical records for verification of history and therapeutic outcomes of trials.)		YES	NO
Drug: _____; Dose: _____; Start & End dates: _____; Outcome: _____			
Drug: _____; Dose: _____; Start & End dates: _____; Outcome: _____			
Drug: _____; Dose: _____; Start & End dates: _____; Outcome: _____			
Comments: _____ _____ _____			
3. Does the patient have an existing cancer diagnosis?		YES	NO
4. Is the prescribing physician's specialty an oncologist or pain management related to oncology?		YES	NO
5. Has restricted drug distribution program enrollment been completed? (Documentation verifying enrollment must be submitted)		YES	NO
<b>*Attachment of a copy of the original prescription, progress notes, and lab reports required. The provider must retain copies of all documentation for five years.</b>			
<b>Authorized Medical Signature:</b>			
<b>Telephone:</b>		<b>Date:</b>	

**When Completed Return To:**

MC-Rx 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.

Prior authorization forms are reviewed at least annually and are available at [www.MC-Rx.com](http://www.MC-Rx.com). Medical Review Criteria are reviewed at least annually. Revised 5/2019