BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND MANAGED CARE

Onsolis

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-888-836-0730**.

Please contact CVS|Caremark at **1-877-203-0814** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Onsolis.

Drug Name (select from list of drugs shown)

Onsolis (fentanyl citrate buccal soluble film)

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each applicable question.

1. Is Actiq being requested? Y N

   [If the answer to this question is no, then skip to question 3.]

2. Is the patient 16 years of age or older? Y N

   [If the answer to this question is yes, then skip to question 4.]

   [If the answer to this question is no, then no further questions are required.]

3. Is the patient 18 years of age or older? Y N

4. Will the oral fentanyl product (e.g., Actiq, Fentora, Onsolis, Abstral) be used to manage breakthrough pain due to a current cancer condition or cancer related complication? Y N

5. Is a long-acting opioid being prescribed for around-the-clock treatment of the cancer pain? Y N

6. Is the patient opioid tolerant? (Patients are considered opioid tolerant if they have been taking at least 60mg of oral morphine per day, 25mcg of transdermal fentanyl/hr, 30mg of oral oxycodone daily, 8mg of oral hydromorphone daily, 25mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer.) Y N

7. Is the patient taking a strong or moderate cytochrome P450 3A4 inhibitor(s) (e.g., ritonavir, ketoconazole, itraconazole, Y N

clarithromycin, nelfinavir, nefazodone, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, or verapamil)?

[If the answer to this question is no, then no further questions are required.]

8. Will the patient be carefully monitored and will dosage adjustments be made if necessary? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature and Date