



**Actiq / Fentora – fentanyl citrate**

**Member Information**

Name \_\_\_\_\_  
Enrollment / Cardholder ID \_\_\_\_\_  
Group / Plan \_\_\_\_\_  
Birth Date \_\_\_\_\_  
Address \_\_\_\_\_  
City State Zip \_\_\_\_\_

**Relationship (Circle)**

Subscriber      Spouse      Dependent  
Gender (Circle)  
Male                      Female  
AGE: \_\_\_\_\_

**Practitioner Information**

Name \_\_\_\_\_  
Agent / Contact Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
Office / Clinic Name \_\_\_\_\_  
Address \_\_\_\_\_  
City State Zip \_\_\_\_\_  
Phone (      ) - \_\_\_\_\_  
Fax (      ) - \_\_\_\_\_  
Email \_\_\_\_\_ @ \_\_\_\_\_

**Primary Diagnosis Condition /  
Diagnosis Related – Reason for Request**

- Does the patient have breakthrough cancer pain? **Y / N**
- Please indicate pain severity:  Mild     Moderate     Severe
- Is the patient currently receiving a long-acting opioid for maintenance (around-the-clock) pain control? **Y / N**
- If yes, please list the medication(s), dose, and schedule:  
\_\_\_\_\_  
\_\_\_\_\_
- Is the medication prescribed by an oncologist or pain specialist?  
**Y / N**
- If yes, please note specialty: \_\_\_\_\_
- Does the patient have acute or postoperative pain? **Y / N**
- Can the patient swallow oral solid dosage forms? **Y / N**

**Strength / Dose**

\_\_\_\_\_

**Duration of Therapy (Expected)**

\_\_\_\_\_

**Formulary Alternatives  
Attempted/Outcome**

\_\_\_\_\_

**Clinical Drug / Lab History Pertinent to Request**

\_\_\_\_\_

Contact Pharmacy?      **Y**      **N**

Pharmacy Phone Number

\_\_\_\_\_

Practitioner Signature

Date Received: \_\_\_\_\_  
Reviewed By: \_\_\_\_\_  
Forwarded To: \_\_\_\_\_

**FAX Form to  
877-800-5633**