



**Duragesic – fentanyl patch, extended-release**

**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 \_\_\_\_\_@\_\_\_\_\_

**Strength / Dose**

**Duration of Therapy (Expected)**

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

Rate the patient's pain on the following scale

0 1 2 3 4 5 6 7 8 9 10

- Will med be used for around-the-clock pain relief? Y / N
- Is the patient's pain chronic? Y / N
- Can the patient swallow oral medications? Y / N
- Is the patient opioid tolerant? Y / N
- If yes, please list the opioid medication(s), dose, and schedule:  
\_\_\_\_\_
- Is the patient under the care of a pain specialist? Y / N

Name of specialist \_\_\_\_\_

Phone no \_\_\_\_\_

(Fax copy of pain consult if available)

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

**Formulary Alternative(s) Attempted? Y / N**

**NSAIDs**

Drug/Dose \_\_\_\_\_

Outcome \_\_\_\_\_

**Opioid Combination (Percocet, Darvocet, ect.)**

Drug/Dose \_\_\_\_\_

Outcome \_\_\_\_\_

**Opioid Analgesics (Oxycodone, Morphine, ect.)**

Drug/Dose \_\_\_\_\_

Outcome \_\_\_\_\_

**Contact Pharmacy?**

Y      N

Pharmacy Phone Number

\_\_\_\_\_

**Practitioner Signature**

Date Received: \_\_\_\_\_

Reviewed By: \_\_\_\_\_

Forwarded To: \_\_\_\_\_

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