



RxAmerica  
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Minnesota Health Care Programs Prior Authorization Request Form  
 Actiq® (fentanyl)

● ● ● Only one medication request per form ● ● ● All fields must be complete and legible for review ● ● ●

<input type="checkbox"/> STANDARD REVIEW		<input type="checkbox"/> EXPEDITED REVIEW	
By selecting the expedited review and signing this form below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.			
<b>PATIENT INFORMATION</b>		<b>PRESCRIBER INFORMATION</b>	
Patient Name:		Prescriber Name and Specialty:	
Member ID#:		DEA #:	
Sex (circle): Male                  Female		Office Phone:	
Date of Birth:		Office Fax:	
Patient Phone:		Contact Person:	
<b>PHARMACY INFORMATION</b>			
Pharmacy Name:	NABP#:	PHARMACY PHONE NO:	PHARMACY FAX NO:
<b>DIAGNOSIS AND MEDICAL INFORMATION</b>			
Medication:	Strength and Route of Administration:	Frequency:	
<input type="checkbox"/> New Prescription – OR – Date Therapy Initiated:     /   /	Expected Length of Therapy:	Quantity:	
Height & Weight:	Drug Allergies:	Diagnosis Related to Medication Requested:	
<b>Rationale for Prior Authorization Request</b>			
Medical Justification for Actiq:			
1. Does the patient have a current diagnosis of cancer or other terminal illness? <input type="checkbox"/> YES <input type="checkbox"/> NO			
2. Is the patient on a long-acting pain medication? <input type="checkbox"/> YES <input type="checkbox"/> NO			
3. Long acting pain medication(s) and dosage(s) _____ _____			
Prescriber's Signature:		Date:	