

**2010 MEDICARE PART D
FENTANYL ORAL OR TRANSDERMAL
PHYSICIAN FAX FORM**



ONLY the prescriber may complete this form. This form is for Medicare Part D requests.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit www.myrxassistant.com and search for the appropriate health plan formulary.

Today's Date: _____

PATIENT, INSURANCE and PHYSICIAN/CLINIC INFORMATION

Patient Name (First):		Last:		M:	DOB (mm/dd/yy):
Insurance ID Number:			Patient Telephone Number:		
Prescribing Physician's Name:		Physician NPI#:		Specialty:	Clinic Contact Person's Name:
Clinic Name:			Clinic Address:		
City, State, Zip:		Clinic Phone #:		Clinic Secure Fax #:	
Is the patient a long term care facility resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the LTC facility contact's name, telephone and fax numbers					
LTC Contact Name:		LTC Phone #:		LTC Secure Fax #:	

DIAGNOSIS ICD-9 code plus description:

MEDICATION REQUESTED:

Strength:

Dosing Schedule:

Quantity per Month:

- Is the patient currently treated with the requested medication? Yes No
 If yes: -When was treatment with the requested medication started? _____
 -Is the patient currently taking a lower dose of the requested medication? (this request is for a higher dose) Yes No
- Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____

- Please list all medications the patient has **previously tried and failed for treatment of this diagnosis**. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____

- Please list any other medications the patient will use in **combination** with the requested medication for treatment of this diagnosis. _____

- Can the patient's episodes of breakthrough pain be controlled by modifying the dose of the long-acting opioid? Yes No
 If no, please provide the reason _____

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 1305 Corporate Center Drive
 Eagan, Minnesota 55121

TOLL FREE

Fax: 800.693.6703 **Phone:** 800.693.6651

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