



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTHORIZATION QUESTIONNAIRE-ACTIQ®

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL\*\***

1. Diagnosis:

- Breakthrough cancer pain       Other (please specify): \_\_\_\_\_

2. Is the patient opioid tolerant? Yes    No

3. Is the patient being currently being treated with a long-acting opioid? Yes    No

If Yes, specify the drug, strength, and frequency \_\_\_\_\_

4. Is the patient being treated for the management of acute or postoperative pain? Yes    No

5. Does the patient have a known intolerance or hypersensitivity to any of its components or the drug fentanyl? Yes    No

6. Is the patient 16 years of age or older? Yes    No

7. Physician Signature or name of person providing answers \_\_\_\_\_

Physician Comments \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

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QUESTIONS PLEASE CALL:  
**877-526-9906**