



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE-ACTIQ®

M.D. Last Name: _____ *M.D. First Name:* _____

Physician Phone: _____ *Physician Fax:* _____

Patient _____ *ID#* _____ *DOB* _____

****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
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

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