



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTHORIZATION QUESTIONNAIRE-FENTORA®

*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 including headache/migraine? 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 18 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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