



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE-ONSOLIS™

<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 pain in patients with cancer 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 acute or postoperative pain including headache/migraine, dental pain, or use in the emergency room? Yes No

5. Does the patient have an intolerance or hypersensitivity to fentanyl, ONSOLIS, or its components? Yes No

6. Is the patient 18 years of age or older? Yes No

7. Physician Signature or name of person providing answers _____

Please Note:

Onsolis is available only through a restricted distribution program called the FOCUS Program and requires prescriber, pharmacy, and patient enrollment.

Physician Comments _____

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

RESTAT
P.O. BOX 758
WEST BEND, WI 53095
www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906