



Physician's Prior Authorization Questionnaire
Actiq®

Patient:

ID#:

DOB:

Patient Address:

Actiq® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the medical diagnosis? (Please do not use codes.)

2. Is the patient opiate tolerant? [] Yes [] No

If Yes, what other pain medications has/is the patient taken/taking?

3. What dose and quantity of Actiq® is the patient being prescribed?

Physician's Signature

Date

Please Print Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx