



# New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Long Acting Narcotic Analgesics

DATE OF MEDICATION REQUEST:      /      /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: [Grid]

FIRST NAME: [Grid]

MEDICAID ID NUMBER: [Grid]

DATE OF BIRTH: [Grid] - [Grid] - [Grid]

GENDER:  Male  Female

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosing Directions: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

## SECTION II: PRESCRIBER INFORMATION

LAST NAME: [Grid]

FIRST NAME: [Grid]

SPECIALTY: \_\_\_\_\_

NPI NUMBER: [Grid]

PHONE NUMBER: [Grid] - [Grid] - [Grid]

FAX NUMBER: [Grid] - [Grid] - [Grid]

## SECTION III: CLINICAL HISTORY

1. What is the condition that this medication is being prescribed for? \_\_\_\_\_

Or select all that apply:

- Pain associated with cancer
- Pain associated with acute sickle cell disease
- Moderate to severe pain which requires continuous pain control for at least 10 days

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

3. Has the patient failed a trial or past therapy with other long acting narcotics?  Yes  No

If YES to question 3, please list treatment failures and provide dates: \_\_\_\_\_

4. Does the patient have a history of opiate tolerance?  Yes  No

5. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days?  Yes  No

6. Does the patient have a written pain agreement?  Yes  No

7. Is the patient currently in a hospice program?  Yes  No

If NO to question 7, is the patient eligible for a hospice program?  Yes  No

8. Has the patient been referred to a pain management clinic or other clinical specialist?  Yes  No

9. Is there any history of alcoholism, substance abuse, unapproved use of other drugs, lost or stolen prescription medications, hoarding or diversion of drugs, obtaining drugs from multiple providers or unsanctioned dose escalations?  Yes  No

If YES to question 9, please explain: \_\_\_\_\_

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_