



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

Methadone (request for pain management only)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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MEDICAID ID NUMBER:

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GENDER: Male Female

Drug Name

FIRST NAME:

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DATE OF BIRTH:

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Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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SPECIALTY:

FIRST NAME:

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NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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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. Does the patient have a history of severe asthma or other lung disease? Yes No

10. If approved, does the patient require concurrent therapy with another long acting narcotic, benzodiazepine, sedative hypnotic or barbiturate? Yes No

11. 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 11, please explain:



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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: _____