



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

buprenorphine/naloxone and buprenorphine (Oral)

DATE OF MEDICATION REQUEST:    /    /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER:                     Male                     Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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## SECTION III: CLINICAL HISTORY:

1. Is this request for treatment of opiate use disorder?  Yes  No

If No, what is the diagnosis for usage: \_\_\_\_\_

2. Does prescriber have a substance abuse and mental health services administration waiver?  Yes  No

3. Is the patient receiving addiction counseling?  Yes  No

4. Has a substance use disorder assessment been performed?  Yes  No

5. Is the patient 16 years of age or older?  Yes  No

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

(Form continued on next page.)



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FIRST NAME:

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**SECTION III: CLINICAL HISTORY (Continued)**

- 7. If approved; will the patient require concurrent opioid medication or methadone therapy?  Yes  No
- 8. Is the patient pregnant or lactating?  Yes  No
- 9. For buprenorphine single agent request ONLY, is there documented allergic reaction to buprenorphine/naloxone combination product (**please provide type of reaction and date**)?  Yes  No

10. 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: \_\_\_\_\_