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

Short-Acting Fentanyl Analgesic Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name **Strength**

Dosing Directions **Length of Therapy**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

SECTION III: CLINICAL HISTORY

1. Is the medication being prescribed for the treatment of breakthrough cancer pain? ☐ Yes ☐ No
2. For what condition is this medication being prescribed? _____
3. What is the patient's age? _____
4. Is the patient already receiving and tolerant to opioid therapy? ☐ Yes ☐ No
5. Has the patient tried and failed immediate-release narcotics for breakthrough pain? ☐ Yes ☐ No
   a. Please list treatment failures and dates: _____
6. Has an oncologist, pain specialist, palliative care specialist, or hospice specialist been consulted on this case? ☐ Yes ☐ No
7. Are you enrolled in the TIRF REMS Access program? ☐ Yes ☐ No

   Prescribers, pharmacies, and patients need to be enrolled in the TIRF REMS Access program.

(Form continued on next page.)

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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(CONTINUED)*

8. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? ☐ Yes ☐ No
9. Do you attest that the risks associated with taking high-dose opioids has been reviewed with the patient? ☐ Yes ☐ No
10. Does the patient have a written pain agreement? ☐ Yes ☐ No
11. Do you attest that you had a discussion with the patient about attempting to taper the dose slowly at an individualized pace? ☐ Yes ☐ No
12. Do you attest that the patient is being monitored to mitigate overdose risk? ☐ Yes ☐ No
13. Will the patient will be prescribed concurrent naloxone? ☐ Yes ☐ No

Provide current opioid (pain management) treatment (drug, dose, frequency, duration):

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**: _____

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