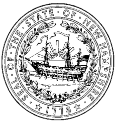


New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

buprenorphine/naloxone and buprenorphine (oral)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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:

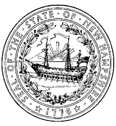
1. Is this request for treatment of opiate use disorder? ☐ Yes ☐ No

   If *no*, what is the diagnosis for usage? ______________________

2. Is the patient receiving addiction counseling? ☐ Yes ☐ No
3. Has a substance use disorder assessment been performed? ☐ Yes ☐ No
4. Is the patient 16 years of age or older? ☐ Yes ☐ No
5. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? ☐ Yes ☐ No
6. If approved, will the patient require concurrent opioid medication or methadone therapy? ☐ Yes ☐ No

(Form continued on next page.)

© 2021–2024 Prime Therapeutics Management LLC, a Prime Therapeutics LLC company



New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
buprenorphine/naloxone and buprenorphine (oral)

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

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

SECTION III: CLINICAL HISTORY *(Continued)*

7. Is the patient pregnant or lactating? ☐ Yes ☐ No

8. *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

____

9. 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**: ________________

Phone: 1-866-675-7755
Fax: 1-888-603-7696

Prime THERAPEUTICS™