Reset Form Print Form

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form

Long-Acting Opioid Analgesic

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. For what condition is this medication being prescribed? _____
   a. Does the patient experience severe, persistent pain which requires continuous pain control for at least 10 days? ☐ Yes ☐ No
2. Is the patient currently in a hospice program or is the patient eligible for a hospice program? ☐ Yes ☐ No
3. Does the patient have pain associated with cancer? ☐ Yes ☐ No
4. Does the patient have pain associated with sickle cell disease? ☐ Yes ☐ No
5. Is the patient 18 years of age or older? ☐ Yes ☐ No
6. Has the patient failed a trial or past therapy with other opioids? ☐ Yes ☐ No
   a. If *yes*, please list treatment failures and provide dates:
   _____
7. Does the patient have a history of opiate tolerance? ☐ Yes ☐ No

(Form continued on next page.)

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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. Does the patient have a written pain agreement? ☐ Yes ☐ No
10. Has the patient tried and failed or is patient not a candidate for at least 3 of the following? ☐ Yes ☐ No
    Provide details below:
    a. Topical NSAIDS: _____
    b. Oral NSAIDS: _____
    c. Oral Acetaminophen: _____
    d. Transcutaneous electrical nerve stimulation: _____
11. Will the patient be prescribed concurrent naloxone? ☐ Yes ☐ No

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

SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction. **Describe reaction:**

☐ Drug-to-drug interaction. **Describe reaction:**

☐ Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**

(Form continued on next page.)

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PATIENT FIRST NAME:

SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA *(Continued)*

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **Provide clinical information:**

_____

☐ Age-specific indications. **Provide patient age and explain:**

_____

☐ Unique clinical indication supported by FDA approval or peer-reviewed literature. **Explain and provide a reference:**

_____

☐ Unacceptable clinical risk associated with therapeutic change. **Please explain:**

_____

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**: _____