Reset Form Print Form

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:

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 is being prescribed? **Select all that apply.**

   ☐ Pain associated with acute sickle cell disease

   ☐ Pain associated with cancer

   ☐ Hospice or end-of-life care

   ☐ Severe, persistent pain that requires continuous around-the-clock pain control for at least 10 days

   ☐ Other: _____

(Form continued on next page.)

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Methadone (request for pain management only)

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME: **PATIENT FIRST NAME:**

SECTION III: CLINICAL HISTORY *(Continued)*

2. Has the patient tried and failed or is not a candidate for at least 3 of the following? ☐ Yes ☐ No
   Provide details below:
   - ☐ Topical NSAIDS: _____
   - ☐ Oral NSAIDS: _____
   - ☐ Oral Acetaminophen: _____
   - ☐ Transcutaneous electrical nerve stimulation: _____
3. Has the patient failed a trial or past therapy with other long-acting opioids? ☐ Yes ☐ No
   a. If *yes*, please list treatment failures and provide dates:
   _____
4. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? ☐ Yes ☐ No
5. Do you attest that the risks associated with taking high-dose opioids have been reviewed with the patient? ☐ Yes ☐ No
6. Does the patient have a written pain agreement? ☐ Yes ☐ No
7. Do you attest that you had a discussion with the patient about attempting to taper the dose slowly at an individualized pace? ☐ Yes ☐ No
8. Do you attest that the patient is being monitored to mitigate overdose risk? ☐ Yes ☐ No
9. Will the patient be prescribed concurrent naloxone? ☐ Yes ☐ No
10. Does the patient have a history of severe asthma or other lung disease? ☐ Yes ☐ No
11. If approved, does the patient require concurrent therapy with another long-acting opioid, benzodiazepine, sedative hypnotic, or barbiturate? ☐ Yes ☐ No

(Form continued on next page.)

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Methadone (request for pain management only)

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

12. 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**: _____

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

Prime THERAPEUTICS™