



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

Morphine Milligram Equivalent (MME)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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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 the prescriber a pain specialist, specialist within the same organ system as the primary pain diagnosis, or has one been consulted in this case? Yes No

2. For what condition is this medication 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.)



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (Continued)

3. Has the patient tried and failed or is patient 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: _____

4. Has the patient failed or had an adequate trial of a lower MME dose? Yes No

a. If yes, list treatment failures and provide dates:

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

6. Do you attest that the risks associated with taking high-dose opioids have been reviewed with the patient? Yes No

7. Does the patient have a written pain agreement? Yes No

8. Do you attest that you had a discussion with the patient about attempting to taper the dose slowly at an individualized pace? Yes No

9. Do you attest that the patient is being monitored to mitigate overdose risk? Yes No

10. Will the patient be prescribed concurrent naloxone? Yes No

11. Does the patient have a history of severe asthma or other lung disease? Yes No

12. Will the patient require concurrent therapy with a benzodiazepine, sedative hypnotic or barbiturate? Yes No

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:** _____