New Hampshire Medicaid Fee-for-Ser	-									
Prior Authorization Drug Approval Fo										
Short-Acting Fentanyl Analgesic Medications DATE OF MEDICATION REQUEST: /	,									
SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED										
	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?									
 For what condition is this medication being prescribed? What is the patient's app? 										
3. What is the patient's age?	erapy? Yes No									
4. Is the patient already receiving and tolerant to opioid therapy?										
5. Has the patient tried and failed immediate-release narcotics for breakthrough pain?										
Please list treatment failures and dates:										
6. Has an oncologist, pain specialist, palliative care special this case?	st, or hospice specialist been consulted on 🗌 Yes 🗌 No									

(Form continued on next page.)





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

Short-Acting Fentanyl Analgesic Medications

DATE OF MEDICATION REQUEST: /

PATIENT LAST NAME:		PATIENT FIRST NAME:								
SECTION III: CLINICAL HISTORY (CONTINUED)										
7. A	re you enrolled in the transmucosal immediate-release	fentanyl Ris	sk Evalua	ation	and M	itigatio	n	Yes	5 🗌 N	0
S	Strategies (TIRF REMS) Access program?									
Prescribers, pharmacies, and patients must be enrolled in the TIRF REMS Access program.										
8.	Do you attest that the NH Prescription Drug Monitorir 60 days?	ng Program	has bee	n revi	ewed	in the l	ast	Yes	5 🗌 N	0
9.	Do you attest that the risks associated with taking hig the patient?	h-dose opio	ids has l	been i	review	ed witl	า [Yes	5 🗌 N	0
10.	Does the patient have a written pain agreement?						[Yes	5 🗌 N	0
11.	Do you attest that you had a discussion with the patie slowly at an individualized pace?	ent about at	temptin	g to ta	aper th	ne dose	e [Yes	5 🗌 N	0
12.	Do you attest that the patient is being monitored to m	nitigate ove	rdose ris	sk?			[Yes	5 🗌 N	0
13.	Will the patient be prescribed concurrent naloxone?						[Yes	5 🗌 N	0
Provide current opioid (pain management) treatment (drug, dose, frequency, duration):										

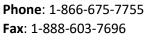
1

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: ___



Prime