Reset Form Print Form

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

Short-Acting Fentanyl Analgesic Medications

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 the medication being prescribed for the treatment of breakthrough cancer pain? ☐ Yes ☐ No
2. For what condition is this medication being prescribed?
3. What is the patient's age?
4. Is the patient already receiving and tolerant to opioid therapy? ☐ Yes ☐ No
5. Has the patient tried and failed immediate-release narcotics for breakthrough pain? ☐ Yes ☐ No

   Please list treatment failures and dates:

6. Has an oncologist, pain specialist, palliative care specialist, or hospice specialist been consulted on this case? ☐ Yes ☐ No

(Form continued on next page.)

Review date: 11/01/2025

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(CONTINUED)*

7. Are you enrolled in the transmucosal immediate-release fentanyl Risk Evaluation and Mitigation Strategies (TIRF REMS) Access program? ☐ Yes ☐ No

   Prescribers, pharmacies, and patients must be enrolled in the TIRF REMS Access program.

8. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? ☐ Yes ☐ No
9. Do you attest that the risks associated with taking high-dose opioids has been reviewed with the patient? ☐ Yes ☐ No
10. Does the patient have a written pain agreement? ☐ Yes ☐ No
11. Do you attest that you had a discussion with the patient about attempting to taper the dose slowly at an individualized pace? ☐ Yes ☐ No
12. Do you attest that the patient is being monitored to mitigate overdose risk? ☐ Yes ☐ No
13. Will the patient be prescribed concurrent naloxone? ☐ Yes ☐ No

Provide current opioid (pain management) treatment (drug, dose, frequency, duration):

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

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