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. Or select all that apply:
   ☐ Pain associated with cancer ☐ Pain associated with acute sickle cell disease ☐ Moderate-to-severe pain which requires continuous pain control for at least 10 days
2. Is the patient currently in a hospice program or is the patient eligible for a hospice program? ☐ Yes ☐ No
3. Is the patient 18 years of age or older? ☐ Yes ☐ No
4. Has the patient failed a trial or past therapy with other opioids? ☐ Yes ☐ No
   a. If *yes*, please list treatment failures and provide dates:
   _____
5. Does the patient have a history of opiate tolerance? ☐ Yes ☐ No

(Form continued on next page.)

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

Review Date: 10/28/2022

Magellan Rx MANAGEMENT

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PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

6. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? ☐ Yes ☐ No
7. Does the patient have a written pain agreement? ☐ Yes ☐ No
8. 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: _____
9. Has the patient been referred to a pain management clinic or other clinical specialist? ☐ Yes ☐ No
10. Will the patient be prescribed concurrent naloxone? ☐ Yes ☐ No
11. Is there any history of alcoholism, substance abuse, unapproved use of other drugs, lost or stolen prescription medications, hoarding or diversion of drugs, obtaining drugs from multiple providers, or unsanctioned dose escalations? ☐ Yes ☐ No
    a. If *yes*, please explain: _____

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**: _____