



**New Hampshire AIDS Drug Assistance Program  
Prior Authorization Drug Approval Form**

buprenorphine/naloxone and buprenorphine (oral)

**DATE OF MEDICATION REQUEST:**    /    /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

**LAST NAME:**

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**FIRST NAME:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**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:**

- Is this request for treatment of opiate use disorder?  Yes  No  
If *no*, what is the diagnosis for usage? \_\_\_\_\_
- Does prescriber have a substance abuse and mental health services administration waiver?  Yes  No
- Is the patient receiving addiction counseling?  Yes  No
- Has a substance use disorder assessment been performed?  Yes  No
- Is the patient 16 years of age or older?  Yes  No
- Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days?  Yes  No

*(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)**

- 7. If approved, will the patient require concurrent opioid medication or methadone therapy?  Yes  No
- 8. Is the patient pregnant or lactating?  Yes  No
- 9. *For buprenorphine single agent request ONLY:* Is there documented allergic reaction to buprenorphine/naloxone combination product? Please provide type of reaction and date:  Yes  No

10. 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:** \_\_\_\_\_