



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

Methadone (request for pain management only)

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 is being prescribed? **Select all that apply.**

- Pain associated with acute sickle cell disease
- Pain associated with cancer
- Moderate to severe pain that requires continuous pain control for at least 10 days
- Other: _____

2. Is the patient currently in a hospice program?

Yes No

a. If no to question 2, is the patient eligible for a hospice program?

Yes No

3. Is the patient 18 years of age or older?

Yes No

(Form continued on next page.)



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

Methadone (request for pain management only)

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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

SECTION III: CLINICAL HISTORY (Continued)

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

5. Has the patient failed a trial or past therapy with other long-acting opioids? Yes No

a. If yes to question 5, please list treatment failures and provide dates:

6. Does the patient have a history of opiate tolerance? Yes No

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

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

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

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

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

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

13. Has the patient been referred to a pain management clinic or other clinical specialist? Yes No

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

15. If approved, does the patient require concurrent therapy with another long-acting opioid, benzodiazepine, sedative hypnotic, or barbiturate? Yes No

(Form continued on next page.)



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

Methadone (request for pain management only)

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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

SECTION III: CLINICAL HISTORY (Continued)

16. Is there any history of alcoholism, substance abuse, unapproved use of other drugs, lost or stolen Yes No prescription medications, hoarding or diversion of drugs, obtaining drugs from multiple providers, or unsanctioned dose escalations?

a. If yes to question 16, please explain:

17. 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:** _____