



TRANSMUCOSAL ANALGESIC MEDICATIONS

New Hampshire Medicaid Prior Authorization

Drug Approval Form

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



Date of Medication Request: ____ / ____ / ____

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____ NH Medicaid Number: _____

Date of Birth: ____ / ____ / ____

Gender: Male Female

Drug Name: _____

Strength: _____

Dosing Directions: _____

Length of Therapy: _____

Section II: Clinical History:

1. Is the medication being prescribed for the treatment of breakthrough cancer pain? Yes No
2. Please provide patient diagnosis for use of this medication: _____
3. What is the patient's age? _____
4. Is the patient already receiving and is 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
7. For Onsolis® only: Are you enrolled in the FOCUS program (restricted distribution program)? Yes No

Please provide current opioid (pain management) treatment (drug, dose, frequency, duration): _____

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Section III: Prescriber Information:

Print Name: _____

NPI Number: _____

Phone Number: (____) _____ - _____

Fax Number: (____) _____ - _____

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.

Signature of Prescribing Provider