



Oxycontin®
New Hampshire Medicaid Prior Authorization Request 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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Name: _____	Strength: _____
Dosing Directions: _____	Length of Therapy: _____

Section II: Clinical History:

1. What is the condition that this medication is being prescribed for? _____
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 18 years of age or older? Yes No

3. Has the patient failed a trial or past therapy with other long acting narcotics? Yes No

If YES to question 3, please list treatment failures and provide dates:

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

5. Is the patient currently in a hospice program? Yes No

If NO to question 5, is the patient eligible for a hospice program? Yes No

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

7. 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

If YES to question 7, please explain:

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: _____ DEA Number: _____

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