Reset Form Print Form

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:

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. Is this request for treatment of opiate use disorder? ☐ Yes ☐ No

   If *no*, what is the diagnosis for usage? _____

2. Is the patient receiving addiction counseling? ☐ Yes ☐ No
3. Has a substance use disorder assessment been performed? ☐ Yes ☐ No
4. Is the patient 16 years of age or older? ☐ Yes ☐ No
5. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? ☐ Yes ☐ No
6. If approved, will the patient require concurrent opioid medication or methadone therapy? ☐ Yes ☐ No

(Form continued on next page.)

Phone: 1-800-424-7901 **Fax**: 1-800-424-7984

Review Date: 06/05/2025

Prime THERAPEUTICS™

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

7. Is the patient pregnant or lactating? ☐ Yes ☐ No

8. *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

9. 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**: _____

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