



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

Short-Acting Fentanyl Analgesic Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

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SECTION III: CLINICAL HISTORY

1. Is the medication being prescribed for the treatment of breakthrough cancer pain? Yes No
2. For what condition is this medication being prescribed? _____
3. What is the patient's age? _____
4. Is the patient already receiving and 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. Are you enrolled in the transmucosal immediate-release fentanyl Risk Evaluation and Mitigation Strategies (TIRF REMS) Access program? Yes No

Prescribers, pharmacies, and patients must be enrolled in the TIRF REMS Access program.

(Form continued on next page.)



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

Short-Acting Fentanyl Analgesic Medications

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (CONTINUED)

8. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? Yes No
9. Do you attest that the risks associated with taking high-dose opioids has been reviewed with the patient? Yes No
10. Does the patient have a written pain agreement? Yes No
11. Do you attest that you had a discussion with the patient about attempting to taper the dose slowly at an individualized pace? Yes No
12. Do you attest that the patient is being monitored to mitigate overdose risk? Yes No
13. Will the patient be prescribed concurrent naloxone? Yes No

Provide current opioid (pain management) treatment (drug, dose, frequency, duration):

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: _____