



**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:

- Is this request for treatment of opiate use disorder? Yes No
If *no*, what is the diagnosis for usage? _____
- Does prescriber have a substance abuse and mental health services administration waiver? Yes No
- Is the patient receiving addiction counseling? Yes No
- Has a substance use disorder assessment been performed? Yes No
- Is the patient 16 years of age or older? Yes No
- Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? Yes No

(Form continued on next page.)



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

buprenorphine/naloxone and buprenorphine (oral)

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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

SECTION III: CLINICAL HISTORY (Continued)

- 7. If approved, will the patient require concurrent opioid medication or methadone therapy? Yes No
- 8. Is the patient pregnant or lactating? Yes No
- 9. *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

10. 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: _____

