Reset Form | Print Form

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Morphine Milligram Equivalent (MME)

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 the prescriber a pain specialist, specialist within the same organ system as the primary pain diagnosis, or has one been consulted in this case? ☐ Yes ☐ No
2. For what condition is this medication being prescribed? Select all that apply.
   - ☐ Pain associated with cancer, hospice, or end of life
   - ☐ Pain associated with acute sickle cell disease
   - ☐ Moderate-to-severe pain that requires continuous pain control for at least 10 days
   - ☐ Other: _____
3. Is the patient 18 years of age or older? ☐ Yes ☐ No

(Form continued on next page.)

© 2016–2022 by Magellan Rx Management, LLC. All rights reserved.

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Morphine Milligram Equivalent (MME)

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME: **PATIENT FIRST NAME:**

SECTION III: CLINICAL HISTORY *(Continued)*

4. Has the patient tried and failed or is patient not a candidate for at least 3 of the following? Provide details below. ☐ Yes ☐ No
   - ☐ Topical NSAIDS: _____
   - ☐ Oral NSAIDS: _____
   - ☐ Oral Acetaminophen: _____
   - ☐ Transcutaneous electrical nerve stimulation: _____
5. Has the patient failed or had an adequate trial of a lower MME dose? ☐ Yes ☐ No
   a. If *yes*, list treatment failures and provide dates:

   _____
6. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? ☐ Yes ☐ No
7. Do you attest that the risks associated with taking high-dose opioids has been reviewed with the patient? ☐ Yes ☐ No
8. Does the patient have a written pain agreement? ☐ Yes ☐ No
9. Do you attest that you had a discussion with the patient about attempting to taper the dose slowly at an individualized pace? ☐ Yes ☐ No
10. Do you attest that the patient is being monitored to mitigate overdose risk? ☐ Yes ☐ No
11. Will the patient be prescribed concurrent naloxone? ☐ Yes ☐ No
12. Does the patient have a history of severe asthma or other lung disease? ☐ Yes ☐ No
13. Will the patient require concurrent therapy with a benzodiazepine, sedative hypnotic or barbiturate? ☐ Yes ☐ No

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**: _____

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

Magellan Rx MANAGEMENT