AmeriHealth Caritas™
New Hampshire

Methadone
(Request for Pain Management Only)
Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / ______

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information	
Prescriber last name:	Prescriber first name:
Prescriber address:	Prescriber representative:
Specialty:	NPI number:
Phone #:	Fax #:

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 opioids? ☐ 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. Do you attest that the NH Prescription Drug Monitoring Program has been reviewed in the last 60 days? ☐ Yes ☐ No
6. Does the patient have a written pain agreement? ☐ Yes ☐ No
7. Is the patient currently in a hospice program? ☐ Yes ☐ No If no to question 7, is the patient eligible for a hospice program? ☐ Yes ☐ No
8. Has the patient been referred to a pain management clinic or other clinical specialist? ☐ Yes ☐ No
9. Does the patient have a history of severe asthma or other lung disease? ☐ Yes ☐ No
10. If approved, does the patient require concurrent therapy with another long acting opioid, benzodiazepine, sedative hypnotic, or barbiturate? ☐ Yes ☐ No
11. 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 11, please explain:
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:________________________________ Date: ______________
(prescriber signature mandatory)

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.