AmeriHealth Caritas New Hampshire

Short-Acting Fentanyl Analgesic

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:	
NPI number:		Specialty:	
Phone #:	Fax #:		

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 TIRF REMS Access program? ☐ Yes ☐ No **Prescribers, pharmacies, and patients need to be enrolled in the TIRF REMS Access program.**
8. Will the patient will 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.

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.