

NEW MEXICO PHARMACIST NALOXONE PRESCRIPTION PROGRAM REPORTING FORM

I. PHARMACY INFORMATION

Pharmacy NPI: [_____]

Patient ID: ___ ___ ___ (assign consecutive numbers to patients, e.g. 0001, 0002 etc)

Pharmacy ZIP Code: ___ ___ ___

DATE : ___ / ___ / ___ (mm/dd/yy)

II. PATIENT INFORMATION

1. Gender: Male Female

2. Patient's current age? _____ (full years)

3. Patients' race: White
 American Indian
 Asian
 Black/African American
 Native Hawaiian/Pacific Islander
 Some other group _____ (specify)

5. Patient's health insurance status:

- No insurance
 Employer-based insurance
 Self-purchased insurance
 Medicaid
 Medicare
 Other: _____ (specify)

4. Is patient Hispanic/Latino: Yes No

III. PRESCRIPTION INFORMATION

1. Is this a First Prescription Refill (check one)

2. Naloxone prescribed by a pharmacist? Yes No

3. Amount prescribed: _____ x 2.0 mg intranasal doses

4. Reason for Naloxone Prescription (check all that apply):

- Rx for high-dose opioid
 Rx for long-term opioid (any ME dose)
 Rx for opioid with concurrent benzodiazepine use
 Rx for opioid with known/suspected alcohol use
 Current poly-opioid use
 History of Opioid Abuse
 Patient request for Naloxone
 Other _____ (specify)

5. Which, if any, of the following substances does the patient currently use (has used in the **past 72 hours**)?

Alcohol: Yes No

Prescription Painkillers: Yes No

Marijuana: Yes No

Methadone: Yes No

Buprenorphine (Subutex®): Yes No

Buprenorphine/Naloxone (Suboxone®) Yes No

Cocaine/Crack: Yes No

Methamphetamine: Yes No

Heroin: Yes No

Benzodiazepines (e.g. Xanax®, Valium®): Yes No

Prescription Sleep Medicine: Yes No

Other _____ (specify)

6. Additional comments: _____

**Please use the Naloxone Data Collection Fax Cover Sheet
to fax completed forms to 505-272-5892**