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)

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
   ☐ Patient request for Naloxone
   ☐ Current poly-opioid use
   ☐ History of Opioid Abuse
   ☐ 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
   Methadone (Subutex®): ☐ Yes ☐ No
   Buprenorphine (Suboxone®): ☐ 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