NEW MEXICO PHARMACIST NALOXONE PRESCRIPTION PROGRAM REPORTING FORM

I. PHARMACY INFORMATION

Pharmacy store # ____ Patient ID: __ __ __ __ ***(First letter of first name, first letter of birth month, two digit day of birth)***

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
5.
6. Patient's health insurance status:
   [ ] No insurance
   [ ] Employer-based insurance
   [ ] Self-purchased insurance
   [ ] Medicaid
   [ ] Medicare
   [ ] Other: _____ *(specify)*

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	Cocaine/Crack:	☐ Yes ☐ No
Prescription Painkillers:	☐ Yes ☐ No	Methamphetamine:	☐ Yes ☐ No
Marijuana:	☐ Yes ☐ No	Heroin:	☐ Yes ☐ No
Methadone:	☐ Yes ☐ No	Benzodiazepines (e.g. Xanax®, Valium®):	☐ Yes ☐ No
Buprenorphine (Subutex®):	☐ Yes ☐ No	Prescription Sleep Medicine:	☐ Yes ☐ No
Buprenorphine/Naloxone (Suboxone®)	☐ Yes ☐ No	Other _____*(specify)*	

6. Additional comments: _____

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