Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
*THERAPEUTIC CANNABIS PROGRAM*

129 PLEASANT STREET, CONCORD, NH 03301-3857
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TDD Access: 1-800-735-2964
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# Written Certification for the Therapeutic Use of Cannabis

## WRITTEN CERTIFICATION INSTRUCTIONS FOR MEDICAL PROVIDERS

**Information about the Therapeutic Cannabis Program, including the enabling law (RSA 126-X), the administrative rules (He-C 400), all required forms, and the "Medical Provider Information Sheet," is available on Program's website at: http://www.dhhs.nh.gov/oos/tcp/index.htm**

1. Type or print in ink your responses on the Written Certification. All certifications on this form that require signature or initialing must be completed in ink. Photocopies or facsimiles of this form will not be accepted.
2. Failure to complete this Written Certification in its entirety will cause your patient's application to be incomplete and the Written Certification to be returned to you.
3. Give the completed Written Certification to your patient to submit to the Program. DO NOT send the form directly to the Program; it must accompany the patient's application.
4. The Program will notify you in writing once your patient's application has been approved.
5. You must be a "provider" as defined in RSA 126-X:1, VII: "(1) A physician licensed to prescribe drugs to humans under RSA 329 and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances; (2) An advanced practice registered nurse licensed to prescribe drugs to humans under RSA 326-B:18 and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances; or (3) A physician or advanced practice registered nurse licensed to prescribe drugs to humans under the relevant state licensing laws in Maine, Massachusetts, or Vermont and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances and who is primarily responsible for the patient's care related to his or her qualifying medical condition."
6. You must have a "provider-patient relationship" with the patient you are certifying. This means that you must have at least a 3-month medical relationship between you and the patient, during which you have conducted a full assessment of the patient's medical history and current medical condition, including an in-person physical examination of the patient; a medical history of the patient, including a prescription history; a review of laboratory testing, imaging, and other relevant tests; appropriate consultations; a diagnosis of the patient's current medical condition; and the development of a treatment plan for the patient appropriate for your specialty. The 3-month requirement shall not apply if the onset or diagnosis of the patient's qualifying medical condition occurred within the past 3 months, and if you are primarily responsible for the patient's care related to his or her qualifying medical condition.
7. Your patient must have a "qualifying medical condition" as defined in RSA 126-X:1, IX(a)(1) or (2):

   (1) "Qualifying medical condition" means the presence of: (A) Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, muscular dystrophy, Crohn's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, epilepsy, lupus, Parkinson's disease, Alzheimer's disease, ulcerative colitis, Ehlers-Danlos syndrome, or one or more injuries or conditions that has resulted in one or more qualifying symptoms under subparagraph (B); and (B) A severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, agitation of Alzheimer's disease, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms. OR

   (2) "Qualifying medical condition" also means: (A) Moderate to severe chronic pain; (B) Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects; or (C) Moderate or severe post-traumatic stress disorder.

# WRITTEN CERTIFICATION FOR THE THERAPEUTIC USE OF CANNABIS

| | |
|---|---|
| ☐ Initial Certification<br>☐ Renewal Certification | If a Renewal Certification, have you previously certified this patient?<br>☐ Yes ☐ No |

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| **Name** | Last | First | Middle |
| **Mailing Address** | P.O. Box/Street | | |
| | City | State | Zip Code |
| **Phone Number** | | | |
| **Date of Birth** | MM/DD/YYYY | | |

## PROVIDER INFORMATION

| | | | | |
|---|---|---|---|---|
| **Name of Physician or APRN** | Last | | First | Middle |
| **Name of Medical Practice** | | | | |
| **Office Mailing Address** | P.O. Box/Street | | County | |
| | City | | State | Zip Code |
| **Office Phone/Fax Number** | Phone | Extension | Fax | |
| **State License Number** | | | ☐ Physician | |
| | | | ☐ Advanced Practice Registered Nurse | |
| **DEA Number** | | | | |
| **Medical Specialty** | | | | |

**Please provide the following information for the person in the office to be contacted by the Program in order to facilitate the processing of this Certification, if different than the provider listed above.**

| | |
|---|---|
| **Name and Title** | |
| **Phone Number** | |
| **Email Address** | |

## PROVIDER'S CERTIFICATION OF A PATIENT'S QUALIFYING MEDICAL CONDITION

**IMPORTANT INSTRUCTIONS – PLEASE READ:**

1. Complete EITHER Box A – Condition / Symptom (both sections), OR Box B – Condition Only
2. Sign and date at the bottom of the page

**A. Condition / Symptom (Check all that apply)**

**I certify that I am treating _____ who has the following condition(s):**
**(Patient Name)**

- ☐ Acquired immune deficiency syndrome
- ☐ Alzheimer's disease
- ☐ Amyotrophic lateral sclerosis
- ☐ Cancer
- ☐ Chronic pancreatitis
- ☐ Crohn's disease
- ☐ Ehlers-Danlos syndrome
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hepatitis C
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ One or more injuries or conditions that has resulted in one or more qualifying symptoms listed below
- ☐ Parkinson's disease
- ☐ Positive status for human immunodeficiency virus
- ☐ Spinal cord injury or disease
- ☐ Traumatic brain injury
- ☐ Ulcerative colitis

**AND who has a severely debilitating or terminal medical condition, or its treatment, that has produced at least one of the following qualifying symptoms or side effects:**

- ☐ Agitation of Alzheimer's disease
- ☐ Cachexia
- ☐ Chemotherapy-induced anorexia
- ☐ Constant or severe nausea
- ☐ Elevated intraocular pressure
- ☐ Moderate to severe vomiting
- ☐ Seizures
- ☐ Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects
- ☐ Severe, persistent muscle spasms
- ☐ Wasting syndrome

**OR**

**B. Condition Only (Check all that apply)**

**I certify that I am treating _____ who has the following condition(s):**
**(Patient Name)**

- ☐ Moderate or severe post-traumatic stress disorder
- ☐ Moderate to severe chronic pain
- ☐ Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects

## SIGNATURE

_____ _____

**Signature of Certifying Provider** **Date**

## PROVIDER'S CERTIFICATION OF A PROVIDER-PATIENT RELATIONSHIP

**INSTRUCTIONS:** Certify that you have a provider-patient relationship with your patient.

"Provider-patient relationship" means at least a 3-month medical relationship between a licensed provider and a patient, unless the 3-month requirement does not apply in accordance with He-C 401.06(b)(1)b., during which the provider has conducted a full assessment of the patient's medical history and current medical condition in accordance with He-C 401.06(b)(2). This rule requires the full assessment to include an in-person physical examination of the patient; a medical history of the patient, including a prescription history; a review of laboratory testing, imaging, and other relevant tests; appropriate consultations; a diagnosis of the patient's current medical condition; and the development of a treatment plan for the patient appropriate for your specialty.

**You must initial one of the following boxes and provide applicable dates.**

| | |
|---|---|
| | I have completed a full assessment of the patient's medical history and current medical condition in accordance with He-C 401.06(b)(2) [as described above] made in the course of a provider-patient relationship of at least 3 months in duration.<br>The dates of the provider-patient relationship are: FROM:_____ TO:_____ |
| | I have completed a full assessment of the patient's medical history and current medical condition in accordance with He-C 401.06(b)(2), [as described above] but I do not have a provider-patient relationship of at least 3 months in duration. The onset or diagnosis of my patient's qualifying medical condition occurred within the past 3 months, and I am primarily responsible for the patient's care related to his or her qualifying medical condition.<br>The date of the onset or diagnosis of my patient's qualifying medical condition is: _____ |

**You must initial the following box.**

| | |
|---|---|
| | I have explained the potential health effects of the therapeutic use of cannabis to my patient.<br>If my patient is a minor, I have explained to my patient's custodial parent or legal guardian with responsibility for health care decisions for the patient both the potential health effects and the potential risks and benefits of the therapeutic use of cannabis. |

**I certify that I am:**

☐ A physician or an advanced practice registered nurse licensed in New Hampshire to prescribe drugs to humans under RSA 329 or RSA 326-B:18, respectively, and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances; OR

☐ A physician or an advanced practice registered nurse licensed in Maine, Massachusetts, or Vermont to prescribe drugs to humans under the relevant state licensing laws, who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances, and who is primarily responsible for my patient's care related to his or her qualifying medical condition.

I possess an active license in good standing with the State of New Hampshire, or the State of Maine, Massachusetts, or Vermont, and the facts as stated in this Written Certification are accurate to the best of my knowledge and belief. I understand that any false statements made on this Certification are punishable as unsworn falsification under RSA 641:3.

_____ _____

**Signature of Certifying Provider** **Date**

## DURATION OF WRITTEN CERTIFICATION

If your patient's Registry Identification Card should be valid for a period shorter than one year, please indicate for how many months the card shall remain valid.

The Registry Identification Card shall remain valid for:

☐ One year from the date of issuance OR ☐ _____ months from the date of issuance

**THIS FORM AS COMPLETED IS NOT INTENDED TO BE A PRESCRIPTION OR MEDICAL RECOMMENDATION FOR THE THERAPEUTIC USE OF CANNABIS**