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coordinated care

MEDICATION ASSISTED TREATMENT
REQUEST FOR BUPRENORPHINE MONOTHERAPY

SECTION 1: Identification of Member and Providers

Last name	First name	Middle initial	Identification Number

Address	City	State	ZIP Code

Phone number ( )	If release is for information about dependent child(ren), name(s) of dependent child(ren)

Physician Name	NPI Number	Physician's phone number ( )

Physician's Address	City	State	ZIP Code

PHARMACY NAME	PHARMACY PHONE NUMBER	City	State	ZIP Code

SECTION 2: Member Authorization for Disclosure of Confidential Information

The above-named Member hereby authorizes the following entities to exchange and disclose to one another information concerning the Member's name and other personal identifying information, their status as a patient, diagnosis, recommended medication(s) and the treatment recommendation(s):

- The Health Care Authority (HCA)
- Any Managed Care Organization (MCO) contracted by HCA to provide your medical care
- The above named physician.
- The above named pharmacy

The purpose of this authorization for disclosure is:

- To initiate an authorization to obtain a prescription and coordinate care.

I understand that my alcohol and/or drug treatment records are protected under Federal and State confidentiality regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: six (6) months from the date signed or the **following specific date, event, or condition upon which this consent expires:**

Member Signature	Date	Guardian or Authorized Representative Signature (if required)	Date

SECTION 3: To be completed by prescriber only—fax completed form to (866)399-0929

☐Member is pregnant with an estimated delivery date (EDD):_____

Members approved based on pregnancy will be approved through their EDD. When the Member is no longer pregnant, transition to a buprenorphine/naloxone combination product is required for ongoing treatment.

☐Naloxone Allergy

You must attach chart notes which document a personally observed allergic reaction not attributable to withdrawal.

I have read and understand *Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment* (http://www.coordinatedcarehealth.com/for-providers/pharmacy-program/). I will complete form HCA 13-333 Medication Assisted Treatment Patient Status if duration of treatment will be greater than six months.

Prescriber signature	Prescriber specialty	Date

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Prescribing Medication Assisted Treatment (MAT)

Prescribers

Authorization is required for Coordinated Care Members to receive some MAT products. Please see the MAT clinical guidelines and coverage limitations under the section titled Medication Assisted Treatment (MAT) at http://www.coordinatedcarehealth.com/for-providers/pharmacy-program/ for a listing of medications and authorization requirements. To request authorization for your patient to receive MAT:

1. Go to MAT clinical guidelines and coverage limitations under the section titled Medication Assisted Treatment (MAT) at http://www.coordinatedcarehealth.com/for-providers/pharmacy-program/.

2. Read *Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment*. You should familiarize yourself with Coordinated Care's requirements for office based substance use disorder treatment prior to prescribing or requesting authorization for MAT.

3. Determine whether the drug you will be prescribing requires authorization:

    - **If no:** Client may receive the product without further authorization requirement. For treatment that will exceed six months, please see 'ongoing treatment' below.

    - **If yes:** **(a)** Select the Medication Assisted Treatment Request form for the drug or dose you will be prescribing. **Both you *and your client* must complete and sign this form.**

      (b) Fax the completed authorization form to Coordinated Care's Pharmacy Benefit Manager, US Scripts, at fax number (866)399-0929.

For ongoing treatment beyond six months:

- If treatment continues for longer than six months, you must complete form **HCA 13-333** Medication Assisted Treatment Patient Status form every six months and maintain it in the patient's records for later audit and review by Health Care Authority (HCA).
- The requirement to complete and maintain the HCA 13-333 Medication Assisted Treatment Patient Status applies to all MAT products, including MAT products that does not requiring require prior authorization. You can obtain the HCA 13-333 Medication Assisted Treatment Patient Status form at http://www.hca.wa.gov/medicaid/pharmacy/Pages/ffs_drug_criteria.aspx.
- Providers are not required to resubmit a Prior Authorization for ongoing treatment beyond six months unless the dosing increment increases.

Drug Specific Criteria

Coordinated Care's *Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment (MAT)* and other drug specific criteria can be found under the section titled Medication Assisted Treatment (MAT) at http://www.coordinatedcarehealth.com/for-providers/pharmacy-program/.