

## MEDICATION ASSISTED TREATMENT IM NALTREXONE

| SECTION 1: Identification of client and providers |   |                          |                        |          |
|---|---|--------------------------|------------------------|----------|
| Last name   | First name  | Middle initial           | ProviderOne ID         |          |
| 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 fax number |          |
| Physician's address                               |   | City                     | State                  | ZIP code |
| Pharmacy name                                     |   | Pharmacy's phone number  | Pharmacy's fax number  |          |
| Pharmacy address                                  |   | City                     | State                  | ZIP code |

| SECTION 2: Patient authorization for disclosure of confidential information  |
|--|
| <p>The above-named patient hereby authorizes the following entities to exchange and disclose to one another information concerning the patient's name and other personal identifying information, their status as a patient, diagnosis, recommended medication(s) and the treatment recommendation(s):</p> <ul style="list-style-type: none"> <li>The Health Care Authority (HCA)</li> <li>Any Managed Care Organization (MCO) contracted by HCA to provide your medical care</li> <li>The above named physician.</li> <li>The above named pharmacy</li> </ul> <p><b>The purpose of this authorization for disclosure is:</b></p> <ul style="list-style-type: none"> <li>To initiate an authorization to obtain a prescription and coordinate care.</li> </ul> <p>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. <b>I also understand</b> 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 <b>following specific date, event, or condition upon which this consent expires:</b></p> |

|                   |      |   |      |
|-------------------|------|---|------|
| Patient signature | Date | Guardian or authorized representative signature (if required) | Date |
|-------------------|------|---|------|

| SECTION 3: To be completed by prescriber only   |  |
|---|--|
| 1. Patient meets criteria for diagnosis of moderate to severe opioid use disorder and patient has been opioid-free long enough to avoid precipitation of severe opioid withdrawal?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Patient meets criteria for diagnosis of moderate to severe alcohol use disorder and patient has stopped drinking and established adequate abstinence to initiate treatment?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Has the patient had previous unsuccessful treatment attempts with oral naltrexone?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Has the patient had a total of three or more emergency room visits, hospital admissions, or other medical services for alcohol or drug related illness, injury, or detoxification in the last 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Does the patient have a co-occurring mental or behavioral health condition which impairs their ability to be compliant with an oral treatment?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, what is the diagnosis, and how does it interfere with treatment compliance:   |  |

I have read and understand *Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment* (<http://www.hca.wa.gov/billers-providers/programs-and-services/apple-health-medicaid-drug-coverage-criteria>). 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.

## Prescribing Medication Assisted Treatment (MAT)

### Prescribers

Authorization is required for Washington Apple Health clients to receive some MAT products. Please see [FFS Drug Coverage Criteria](#) at <http://www.hca.wa.gov/billers-providers/programs-and-services/apple-health-medicaid-drug-coverage-criteria> for a listing of medications and authorization requirements. To request authorization for your patient to receive MAT:

- Go to [FFS Drug Coverage Criteria](#) at <http://www.hca.wa.gov/billers-providers/programs-and-services/apple-health-medicaid-drug-coverage-criteria>
- Read *Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment*. You should familiarize yourself with HCA's requirements for office based substance use disorder treatment prior to prescribing or requesting authorization for MAT.
- 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:**
    - 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.
    - Fax the completed form to the pharmacy which will be filling the prescription and dispensing to your patient.
    - Alternately, you may provide the forms to your patient to hand deliver to their pharmacy of choice. The documents MUST be available at the pharmacy for them to request the authorization to dispense MAT.

#### 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.
- The requirement to complete and maintain the Medication Assisted Treatment Patient Status applies to all MAT, including those not requiring prior authorization.

### Pharmacies

To submit a request for MAT requiring authorization you must:

- Complete the agency's *Pharmacy Information Authorization* (13-835A) form as you would for any other authorization request.
- As supporting documentation to the *Pharmacy Information Authorization* (13-835A), attach Medication Assisted Treatment Request form (13-330, 13-331, or 13-332) completed by the prescriber.
- Fax both documents to HCA at: (866) 668-1214. The *Pharmacy Information Authorization* 13-835A must be the first document in the fax transmission.
- Authorization requests will not be reviewed until all necessary documents are received by the agency. Please be proactive in obtaining completed forms prior to requesting authorization.

### Drug Specific Criteria

The agency's *Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment (MAT)* and other drug specific criteria can be found on [FFS Drug Coverage Criteria](#) at <http://www.hca.wa.gov/billers-providers/programs-and-services/apple-health-medicaid-drug-coverage-criteria>

Links to form Medication Assisted Treatment Request forms can be found at this same site. These same forms and the Pharmacy Information Authorization (13-835A) can be found at: <http://www.hca.wa.gov/billers-providers/forms-and-publications>