Washington State Health Care Authority

Medication Assisted Treatment

Buprenorphine/Naloxone > 32mg Per Day

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

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):

- 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: twelve (12) months from the date signed or the **following specific date, event, or condition upon which this consent expires:**

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

SECTION 3: To be completed by prescriber only

Patient has been unable to maintain abstinence from other opioids at a dose of 32mg/ day? ☐ Yes ☐ No

If Yes, supporting documentation such as urine drug tests must be submitted with this request.

Has the patient complied with scheduled visits and requests to return for pill counts? ☐ Yes ☐ No

Has the patient complied with provision of urine samples as requested? ☐ Yes ☐ No

Has the patient complied with all other treatment requirements you have set for them? ☐ Yes ☐ No

Urine drug tests show the presence of buprenorphine and its metabolite? ☐ Yes ☐ No

If Yes to all of the above, attach supporting labs, chart notes, and treatment records.

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 twelve 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 medical 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.

Washington State Health Care Authority

Prescribing Medication Assisted Treatment (MAT)

Prescribers

Authorization is required for Washington Apple Health clients to receive some MAT products. Please see Apple Health (Medicaid) 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 Apple Health (Medicaid) 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 twelve 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 twelve months:

- If treatment continues for longer than twelve months, you must complete form HCA 13-333 Medication Assisted Treatment Patient Status form every twelve 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 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 Apple Health (Medicaid) Drug Coverage Criteria at http://www.hca.wa.gov/billers-providers/programs-and-services/apple-health-medicaid-drug-coverage-criteria

Links to 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