Washington State Health Care Authority

# Medication Assisted Treatment
# Patient Status and Progress

## 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 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 purpose of this authorization for disclosure is:**

- To document progress of recovery 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 every twelve months and maintained in the patient's file

If patient does not have a past/current history of mental health diagnosis, screens for depression and anxiety have been performed as a baseline: ☐ Yes ☐ No

Suicide screen performed: ☐ Yes ☐ No

PMP database checked: ☐ Yes ☐ No Date:

Is there evidence of multiple prescribers?: ☐ Yes ☐ No

If yes, were you aware of and approved other opioid prescriptions? ☐ Yes ☐ No

Urine drug screens demonstrate patient is taking prescribed medications: ☐ Yes ☐ No

Urine tests demonstrate abstinence or near abstinence from opioids ☐ Yes ☐ No

Urine tests demonstrate abstinence or near abstinence from other illicit drugs ☐ Yes ☐ No

Opioids : ☐ No use after stabilization ☐ Infrequent use ☐ Problematic use

Alcohol/other illicit drugs: ☐ No use ☐ Infrequent use ☐ Problematic use

ED visits/hospitalizations: ☐ None ☐ Decreased ☐ Same ☐ Increased

Medical co-morbidity: ☐ None/minor ☐ Major problem/engaged in care ☐ Major problem/unengaged in care

Psychiatric co-morbidity: ☐ None/minor ☐ Major problem/engaged in care ☐ Major problem/unengaged in care

Legal issues: ☐ None/minor ☐ Major problem/being addressed ☐ Major problem/not being addressed

Family-social problems: ☐ None/minor ☐ Major:_____ ☐ Homeless/unstable housing

School/work: ☐ Full time ☐ Part time ☐ Episodic ☐ None ☐ Disabled

Participation in recovery support activities*: ☐ Multiple times a week ☐ Weekly ☐ Episodic ☐ None

*AA/NA, spiritual programs, other support groups, counseling, meetings

| 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.

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# 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