SUBSTANCE USE DISORDER (SUD) PRIOR AUTHORIZATION REQUEST

PERSON COMPLETING AND SUBMITTING THIS FORM:

Name:	NPI:	Facility:
Phone number:	Fax:	Date form submitted:

MEMBER INFORMATION:

Member name:	DOB:
State ID:	SSN:

Select the line of business or organization this request is for (*check all that apply*):

- ☐ Child Health Plan *Plus* offered by Colorado Access
- ☐ Child Health Plan *Plus* State Managed Care Network
- ☐ Regional Accountable Entity - Denver Health MCO (RAE DH MCO)
- ☐ Regional Accountable Entity (RAE) 3
- ☐ Regional Accountable Entity (RAE) 5

Primary diagnosis (ICD-10):	Secondary diagnosis (ICD-10):

SERVICE PRIORITY:

- ☐ Prospective (service has not yet been rendered/patient not yet admitted).
- ☐ Retrospective (service already rendered). Please explain why prior authorization was not completed:

REMEMBER TO ATTACH A COMPLETE SUBSTANCE USE AND PSYCHOSOCIAL EVALUATION WITH THIS REQUEST TO AVOID PROCESSING DELAYS.

We are not financially responsible for the services that are preauthorized if the patient is not eligible on the date services are provided. This request is not a guarantee of payment. Eligibility must be verified at the time the services are rendered. If you have questions regarding eligibility of a patient, please call us at the numbers below.

Confidentiality Notice:
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After completing this form, send it to us by fax at 720-744-5130 or email it to us at behavioral.health@coaccess.com | 24 hours a day, seven days a week

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SUBSTANCE USE DISORDER (SUD) PRIOR AUTHORIZATION REQUEST (CONTINUED)

Please make sure to fill out this form in its entirety. Incomplete forms will be returned to you for completion before authorization request will be processed.

ASAM SUBSTANCE USE SERVICES BEING REQUESTED (1 unit = 1 day)

Code/description	Units requested
ASAM 2.1 Intensive Outpatient Services HCPC code: H0015 Modifier 1st position: HE OR Revenue code 0906	Total # of units requested: Number of services (up to 19 hours weekly) rendered per week:
ASAM 3.1 Clinical Managed Low-Intensity Residential Services HCPC code: H2036 Modifier 1st position: HF Modifier 2nd position: U1	
ASAM 3.3 Clinically Managed Low-Intensity Residential Services HCPC code: H2036 Modifier 1st position: HF Modifier 2nd position: U3	
ASAM 3.5 Clinically Managed High-Intensity Residential Services HCPC code: H2036 Modifier 1st position: HF Modifier 2nd position: U5	
ASAM 3.7 Medically Monitored Intensive Inpatient Services Revenue code: 1000 Modifier 1st position: HF Modifier 2nd position: U7	
ASAM 3.7WM Medically Monitored Withdrawal Management Services Revenue code: 1002 Modifier 1st position: HF	

ESTIMATED SERVICE START DATE: _____

ESTIMATED END DATE FOR THIS EPISODE OF CARE: _____

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SUBSTANCE USE DISORDER (SUD) PRIOR AUTHORIZATION REQUEST (CONTINUED)

Primary diagnosis (ICD-10): _____ Secondary diagnosis: (ICD-10) _____

Additional diagnosis: _____

Substance	Age of first use	Typical frequency of use	Approximate date of last use	Amount of last use
Alcohol				
Marijuana/synthetics				
Cocaine				
Amphetamines				
Heroin				
Other opioids				
Benzodiazepines				
Psychedelics				
Other prescriptions				
Other substances				

Please list any other information about the member's substance use history and/or current use.

_____

SUBSTANCE USE DISORDER TREATMENT HISTORY: Describe services utilized in the past 12 months.

ASAM LOC	Name of provider	Duration	Approximate time	Outcome

MEDICATIONS: Please list all current medications, dosage, frequency, and prescriber below (or attach medication list).

☐ N/A ☐ Unable to obtain

Name of medication	Dosage	Frequency	Prescriber

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ASAM ASSESSMENT AND SCORING: Please make sure all relevant clinical assessment documentation is submitted with this request.

DIMENSION 1 | Acute intoxication and/or withdrawal potential	
☐	No significant withdrawal risk (Level 1)
☐	Minimal risk of severe withdrawal (Level 2.1)
☐	Not at risk of withdrawal, or is experiencing minimal or stable withdrawal (Level 3.1)
☐	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2WM (Level 3.3-3.5)
☐	Patient has potential for life threatening withdrawal (Level 3.7 WM)
☐	Life threatening withdrawal symptoms, possible or experiencing seizures or DT's or other adverse reactions are imminent (Level 4.0)
Brief summary of clinical rationale for score chosen:	

DIMENSION 2 | Biomedical conditions and complications	
☐	None or not significant to distract from treatment (Level 2.1)
☐	None or stable, or patient is receiving concurrent medical monitoring, moderate stability (Level 3.1, 3.3, or 3.5)
☐	Patient required 24-hour medical monitoring but not intensive treatment (level 3.7)
☐	Patient requires 24-hour medical and nursing care and the full resources of a licensed hospital (Level 4)
Brief summary of clinical rationale for score chosen:	

Continued on the next page

DIMENSION 3 | Emotional, behavioral, cognitive conditions or complications	
☐	None or very stable (Level 1)
☐	Mild severity, with potential to distract from recovery; needs monitoring (Level 2.1)
☐	Mild or minimal; not distracting to recovery (Level 3.1)
☐	Mild to moderate severity: Patient needs structure to focus on recovery. Has population-specific needs than cannot be met in Level 3.1 (Level 3.3)
☐	Patient demonstrates repeated inability to control impulses, or is unstable with symptoms requiring stabilization (Level 3.5)
☐	Moderate severity: Patient needs a 24-hour structured, medically-monitored setting (Level 3.7)
☐	Severely unstable and required 24-hour psychiatric care (Level 4.0)
Brief summary of clinical rationale for score chosen:	

DIMENSION 4 | Readiness to change	
☐	Readiness for recovery but needs motivating and monitoring strategies to strengthen readiness, or needs ongoing monitoring and disease management (Level 1)
☐	Variable engagement in treatment, ambivalence or lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment several times per week to promote change (Level 2.1)
☐	Patient is open to recovery, but needs a structured environment to maintain therapeutic gains (Level 3.1)
☐	Patient has little awareness of need for change due to cognitive limitations and addiction; requires interventions to engage to stay in treatment (Level 3.3)
☐	Patient has marked difficulty with, or opposition to, treatment with dangerous consequences (Level 3.5)
☐	Patient's resistance is high and impulse control poor, despite negative consequences, needs motivating strategies available only in a 24-hour structured setting (Level 3.7)
Brief summary of clinical rationale for score chosen:	

Continued on the next page

DIMENSION 5 | Relapse, continued use, continued problem potential	
☐	Minimal support required to control use, needs support to change behaviors (Level 1)
☐	High likelihood of relapse/continued use or addictive behaviors, requires services several times per week (Level 2.1)
☐	Patient understands relapse but needs structure to maintain therapeutic gains (Level 3.1)
☐	Patient has little awareness and needs interventions available only at Level 3.3 to prevent continued use, with imminent dangerous consequences, because of cognitive deficits or comparable dysfunction (Level 3.3)
☐	Patient has psychiatric symptoms, cravings, or crises that inhibit the ability to control one's substance use (Level 3.5)
☐	Patient unable to control use, requires 24-hour supervision, imminent dangerous consequences (Level 3.7)
Brief summary of clinical rationale for score chosen:	

DIMENSION 6 | Recovery environment	
☐	Has supportive recovery environment and/or skills to cope with stressors (Level 1)
☐	Recovery environment not fully supportive; but, with structure and support, patient can cope (Level 2.1)
☐	Patient's environment is dangerous, patient needs 24-hour structure to cope (Level 3.1 or 3.3)
☐	Patient's environment is imminently dangerous, patient lacks skills to cope outside of a highly structured 24-hour setting
Brief summary of clinical rationale for score chosen:	

☐ **For patients with an opioid use disorder, I attest that the provider has completed the following:**

- Educated the patient that medically-assisted treatment (MAT) is the standard of care;
- Performed an assessment that specifically addresses MAT with specific recommendations; and,
- Documented how patient will receive access to MAT for both withdrawal management and maintenance, including coordination of access when clinically indicated.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form must be filled out completely to be valid.

Member Name:_____ Member ID:_____

I give Colorado Access and the person/organization listed below permission to exchange and share my health information

_____	_____	_____	
Name	Phone number	Fax number	
_____	_____	_____	_____
Address (optional)	City	State	Zip code

Please make selections in the following three (3) sections:

My information may be shared for the following purpose (you must mark a selection):

☒ Care coordination/treatment
☐ To explain benefits and coverage
☐ Legal representation
☐ Grievance and/or appeal representation
☐ At my request
☐ Other _____

By marking one (1) of the boxes below, I give permission to share the following information:

☒ All health records

OR

☐ Only limited information may be shared (select the information you would like to share below).

_____ Billing and claims information/Prior authorizations
_____ Eligibility information
_____ Case management notes/plans
_____ Demographic information
_____ Other - please specify _____

Specific health information will not be shared, unless I select this information below:

_____ HIV/AIDS related information and/or records
_____ Genetic testing information
__X__ Drug/alcohol diagnosis, treatment and referral information

The information to be shared covers the following dates of service: _____

My permission will expire one (1) year from the date this authorization is signed, unless I change my permission below: Specific date of expiration: ___/___/___(MM/DD/YY) not to exceed two (2) years.

Authorization Statements

I am voluntarily signing this authorization. I understand that I may refuse to sign this authorization. If I refuse to sign this authorization my health care benefits or payment for my healthcare benefits will not be affected.

I may cancel this authorization at any time. To cancel this authorization, I may call Colorado Access at 855-879-8286, TTY/TDD users call 888-803-4494 or send an email to privacy@coaccess.com. I understand that if I cancel this authorization, it will not affect information that was shared before Colorado Access received my written cancellation.

I understand that if I give Colorado Access permission to share my information, the people or organizations who receive my information may not be required to protect my information.

_____ _____

Signature of the member or personal representative Date

_____ _____

Print the name of the member's personal representative Date

_____

Description of personal representative's authority

Personal Representatives: If you are signing this authorization on behalf of a member, you must include documentation that supports your authority to make health care decisions on behalf of the member.

Minors: Minors 15 years and older may authorize the release of mental health information by signing this form. Minors of any age may authorize the release of health care information related to the treatment of sexually transmitted diseases, including HIV/AIDS, alcohol and/or drug abuse treatment, contraception treatment, and prenatal care services by signing this form.

If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

Si necesita este documento en letra grande, Braille, otros formatos o idiomas, o se lea en voz alta, o necesita otra copia, llame al 800-511-5010. Para TDD/TTY, llame al 888-803-4494. Llame de lunes a viernes, de 8 a.m. a 5 p.m. La llamada es gratis.