SUBSTANCE USE DISORDER (SUD) AUTHORIZATION REQUEST - ASAM LEVEL 3.7WM

*ASAM level 3.7 withdrawal management services **only***

PERSON COMPLETING AND SUBMITTING THIS FORM:

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

ADMITTING FACILITY (IF KNOWN):

Facility name:

NPI:	Anticipated/Actual admit date:

MEMBER INFORMATION:

Member name:

DOB:	State ID:

Select the line of business or organization this request is for:

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

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

SERVICE PRIORITY:

- ☐ Prospective (patient not yet admitted for services).
- ☐ Concurrent (patient has already started services and needs additional services).

Please complete the following section and attach any relevant clinical information to support this request.

Withdrawal substance(s): for each substance requiring withdrawal management, please list any use information/history that is relevant to the withdrawal risk:

Substance	**Relevant use information/history**	
☐ Alcohol		Current blood alcohol level (BAL):
☐ Heroin		Positive toxicology screen? ☐ Yes ☐ No
☐ Other opiates		Positive toxicology screen? ☐ Yes ☐ No
☐ Benzodiazepines		Positive toxicology screen? ☐ Yes ☐ No

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SUBSTANCE USE DISORDER (SUD) PRIOR AUTHORIZATION REQUEST - ASAM LEVEL 3.7WM

☐ Other (please specify)		Positive toxicology screen? ☐ Yes ☐ No

Biomedical Conditions/Considerations:

☐ Headache	☐ Body aches	☐ Tremors	☐ Cravings
☐ Abdominal pain	☐ Stomach cramps	☐ Fever	☐ Diabetes
☐ Seizures or ☐ History of seizures	☐ Nausea/vomiting	☐ Sweats/chills	☐ Insomnia
☐ Delirium tremens or ☐ History of delirium tremens	☐ Diarrhea	☐ Hypertension	☐ Asthma

☐ Other (please specify):_____

Current vitals:

Blood pressure:	Oxygen:
Pulse:	Respiration:

Medications:

Any withdrawal medications already initiated:
Any other medications:

Mental Health Considerations:

☐ Suicidal ideation

☐ Homicidal ideation

☐ Psychosis/paranoia/grave disability

If yes, please give explanation:

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