

SUBOXONE[®] Authorization

ATTENTION

In order for Health Care Authority (HCA) to reimburse for this medication, the patient listed below **must currently** be enrolled in state-certified chemical dependency treatment and meet the criterion for this medication. Complete Sections 1 through 4 of the form. Instructions for proper completion are on page 2 of this form. **Send the completed form to the Division of Behavioral Health and Recovery (DBHR) by fax at 360-725-2279 for review.**

1. CHEMICAL DEPENDENCY TREATMENT AGENCY SECTION

NAME OF DBHR CERTIFIED CHEMICAL DEPENDENCY TREATMENT AGENCY

AGENCY NUMBER (USE NUMBER IN "DIRECTORY OF CERTIFIED CHEMICAL DEPENDENCY SERVICES IN WASHINGTON STATE")

2. PATIENT SECTION

PATIENT'S NAME

BIRTHDATE

PATIENT'S MEDICAID PROVIDERONE NUMBER

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 recommendations(s):

- The CDP and/or certified chemical dependency treatment agency in Section 1 above.
- Health Care Authority (HCA).
- Department of Social and Health Services - Division of Behavioral Health and Recovery.
- The physician named in Section 3.
- The pharmacy named in Section 4.

The purpose of this authorization for disclosure is:

- To initiate an authorization to obtain a prescription for **SUBOXONE[®]** and coordinate care.
- To verify patient's involvement in state-certified chemical dependency treatment.

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

PATIENT'S SIGNATURE

DATE

SIGNATURE OF PARENT, GUARDIAN, OR AUTHORIZED REPRESENTATIVE (WHEN REQUIRED)

DATE

3. PHYSICIAN SECTION

PHYSICIAN NAME

TELEPHONE NUMBER

SUBOXONE DEA ID NUMBER

ADDRESS

CITY

STATE

ZIP CODE

I have read HCA's Criteria For Authorization of **SUBOXONE[®]** at <http://www.hca.wa.gov/medicaid/pharmacy/pages/index.aspx> and attest that all criteria and limiting conditions have been satisfied. Yes No

SUBOXONE WAIVERED PHYSICIAN SIGNATURE

DATE

OPIATE DEPENDENT

PROPOSED MEDICATION START DATE

4. PHARMACY SECTION

PHARMACY NAME

PHARMACY NPI

HCA will reimburse for **SUBOXONE[®]** only when these conditions are met:

1. The medication is provided in conjunction with a comprehensive chemical dependency treatment program as verified by completion of Section 1.
2. Payment for the medication is limited to six (6) months of continuous use. The medication is limited to a 14-day supply on each fill.

AREA CODE AND TELEPHONE NUMBER

FAX NUMBER

DATE

ADDRESS

CITY

STATE

ZIP CODE

FOR DBHR USE ONLY: APPROVED DENIED BASED ON: _____

DBHR SIGNATURE: _____ DATE: _____ RESPONSE SENT DATE: _____

SUBOXONE® Authorization Form Instructions

Health Care Authority (HCA) provides coverage for a **SUBOXONE®** prescription up to six months with prior authorization from HCA. The patient must be currently enrolled in a state-certified chemical dependency treatment program and meet the Medicaid Prescription Drug Program criteria for **SUBOXONE®**. You can find the HCA Criteria for Authorization of SUBOXONE® at <http://www.hca.wa.gov/medicaid/pharmacy/pages/index.aspx>. To locate Division of Behavioral Health and Recovery (DBHR) certified chemical dependency treatment agency and agency number, see the "Directory of Certified Chemical Dependency Services in Washington State: <http://www.dshs.wa.gov/dbhr/dadirectory.shtml>.

Where is the completed form sent?

Fax completed form to DSHS/DBHR for prior authorization to:

Attn: DBHR Certification Policy Manager/DSHS-HRSA

Fax: (360) 725-2279, or mail to: Post Office Box 45330, Olympia, Washington 98504-5330

1. Complete **SECTION 1. CHEMICAL DEPENDENCY TREATMENT AGENCY SECTION:**

- Enter the name of the DBHR certified chemical dependency treatment agency and the agency's 8-digit certification agency identification number found in the "Directory of Certified Chemical Dependency Services in Washington State," published by DBHR.
- The Chemical Dependency Professional (CDP) at the chemical dependency treatment agency should keep a copy in the patient's record.

2. Complete **SECTION 2. PATIENT SECTION:**

- Enter the patient's name.
- Enter the patient's date of birth.
- Enter the patient's Medicaid ProviderOne number.
- Complete the **PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION**, being sure the CDP discusses this disclosure with the patient. Have the patient sign and date it (or their guardian or authorized representative, when required).

3. Complete **SECTION 3. PHYSICIAN SECTION:**

- Enter the name of the physician, telephone number, and the physician's **SUBOXONE®** DEA ID number.
- Enter the physician's address and attest to the patient's compliance with the **SUBOXONE®** criteria.
- The **SUBOXONE®** waived physician is to sign, date, verify the opiate diagnosis, and the proposed medication start date.
- The physician should keep a copy of the **SUBOXONE® Authorization** form for the medical record.
- The physician will give the patient copies of the **SUBOXONE® Authorization** form to take to the CDP, and then to the pharmacy to obtain the prescription.

4. Complete **SECTION 4. PHARMACY SECTION:**

- Enter the name of the pharmacy and pharmacy NPI number.
- Enter the pharmacy area code with telephone number, fax number, and date.
- Enter the address of the pharmacy.
- Fax completed form to DBHR for verification of treatment. DBHR will fax to HCA for prior authorization.

Information about Patient's Right to Revoke Authorization: A revocation requires only that a line be drawn through the document, with the word "Revoked," and the date and time of revocation. The patient need not initial a revocation. A patient may request revocation by any means, including by telephone, provided their identity is confirmed.

The following notice should accompany all documents released under the Patient's Authorization for Disclosure of Confidential Information on the other side of this form:

NOTICE PROHIBITING REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT INFORMATION

Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (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.