

## CAMPRAL® 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 criteria for this medication located at: <http://www.hca.wa.gov/medicaid/pharmacy/pages/index.aspx> . Complete Sections 1 through 4 of the form. Instructions for proper completion are on page 2 of this form.

### 1. CHEMICAL DEPENDENCY TREATMENT AGENCY SECTION

NAME OF DIVISION OF BEHAVIORAL HEALTH AND RECOVERY (DBHR) CERTIFIED CHEMICAL DEPENDENCY TREATMENT AGENCY	AGENCY NUMBER (USE NUMBER IN "DIRECTORY OF CERTIFIED CHEMICAL DEPENDENCY SERVICES IN WASHINGTON STATE")
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### 2. PATIENT SECTION

PATIENT'S NAME	BIRTHDATE	PATIENT'S MEDICAID PROVIDERONE ID NUMBER
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### 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 **CAMPRAL®** 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
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### 3. PHYSICIAN SECTION

PHYSICIAN'S NAME	TELEPHONE NUMBER (WITH AREA CODE)	DEA NUMBER
ADDRESS	CITY	STATE      ZIP CODE
PHYSICIAN'S SIGNATURE	DATE	MEDICATION START DATE

### 4. PHARMACY SECTION

PHARMACY'S NAME	NPI NUMBER
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I have received a prescription for **CAMPRAL®** for the patient named above from the patient's physician and have filled the prescription as authorized. I understand that reimbursement by HCA for **CAMPRAL®** shall only be made under the following conditions:

1. The medication is provided in conjunction with a chemical dependency treatment program as verified by completion of Section 1.
2. Payment for the medication is limited to twelve (12) months of continuous use.
3. Record of this certification shall be kept on file at the pharmacy for Medicaid audit purposes. Prescriptions reimbursed by HCA for **CAMPRAL®** without this certification record on file shall be considered an overpayment.

TELEPHONE NUMBER (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)	DATE
ADDRESS	CITY	STATE      ZIP CODE

## CAMPRAL<sup>®</sup> Authorization Form Instructions

Health Care Authority (HCA) extends coverage for a **CAMPRAL<sup>®</sup>** prescription up to twelve months. The patient must be currently enrolled in a state-certified chemical dependency treatment program and meet the Medicaid Prescription Drug Program criteria at: <http://www.hca.wa.gov/medicaid/pharmacy/pages/index.aspx> for **CAMPRAL<sup>®</sup>**. Chemical dependency treatment programs and the agency number can be located by county at: <http://www.dshs.wa.gov/dbhr/dadirectory.shtml>.

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

- Enter the name of the Division of Behavioral Health and Recovery (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 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 ID number.
- Complete the **Patient Authorization for Disclosure of Confidential Information**, being sure the CDP discusses this disclosure with the patient and 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 DEA number.
- Enter the physician's address.
- The physician is to sign and date, and enter the proposed **CAMPRAL<sup>®</sup>** medication start date.
- The physician should keep a copy of the **CAMPRAL<sup>®</sup> Authorization** form for the medical record.
- The physician will give the patient the **CAMPRAL<sup>®</sup> 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 NPI number.
- The pharmacist's telephone number (with area code).
- Enter the fax number (with area code) and date.
- The pharmacist keeps the copy on file at the pharmacy for future Medicaid audit purposes.

**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 the 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 Rediscovery 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.