

# SUBOXONE<sup>®</sup> Exemption Request

## ATTENTION

In order for the Health Care Authority (HCA) to consider an exemption, the patient listed below **must currently** be enrolled in state-certified chemical dependency treatment and making progress in functioning levels. A completed form must be returned 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 THE 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 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 DBHR certified chemical dependency treatment agency in Section 1 above.
- Health Care Authority.
- Department of Social and Health Services - Division of Behavioral Health and Recovery
- The physician named in Section 2.
- The pharmacy named in Section 3.

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

- To initiate an authorization to obtain a prescription for **SUBOXONE<sup>®</sup>** 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: Six 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 PRINTED NAME	AREA CODE AND TELEPHONE NUMBER	FAX NUMBER
SUBOXONE WAIVERED PHYSICIAN'S SIGNATURE	DATE	SUBOXONE DEA ID NUMBER

**PHYSICIAN'S DECLARATION:** Up to a six-month exemption has been discussed with the above patient. The patient and physician understand that only one six-month exemption to the limitation of HCA's payment for the prescription will be granted. The patient is opiate dependent with opiate dependency as the primary diagnosis.

RATE CURRENT FUCTION LEVEL:	INCREASE	NO CHANGE	DECREASE
ER Visits			
Hospital Admissions			
Criminal Behavior			
Productive Activity; Work or School			
Use of Drugs and/or Alcohol			
Participation in Chemical Dependency Treatment			
Participation in Mental Health Treatment			
Compliance with Psychiatric Medications			
Stability of Patient's Home Environment/Social Relationships			
Behavioral Problems			

BRIEFLY LIST KEY ISSUES WHICH SUPPORT YOUR REQUEST OF EXEMPTION

### 3. PHARMACY SECTION

PHARMACY NAME	AREA CODE AND TELEPHONE NUMBER	FAX NUMBER
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FOR DBHR USE ONLY:  APPROVED  DENIED BASED ON: \_\_\_\_\_

DBHR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  RESPONSE SENT DATE: \_\_\_\_\_

# SUBOXONE<sup>®</sup> Exemption Request Form Instructions

## What is the purpose of an exemption request?

Health Care Authority (HCA) extends coverage for a **SUBOXONE**<sup>®</sup> prescription up to six months. The exemption requests MPA to pay for an additional six-month prescription. The patient must be currently enrolled in a state-certified chemical dependency treatment program, making progress in current functioning levels and meet the Medicaid Prescription Drug Criteria located at: <http://www.hca.wa.gov/medicaid/pharmacy/pages/index.aspx> in order to qualify for the exemption. Chemical dependency treatment programs and the agency number can be located by county at: <http://www.dshs.wa.gov/dbhr/dadirectory.shtml>.

## Where is the completed form sent?

### Fax completed form to DSHS/DBHR at:

Attn: DBHR Certification Policy Manager/DSHS

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

## How is the form completed?

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.
2. Complete **SECTION 2. PATIENT SECTION:**
  - Enter patient name, birth date, and patient Medicaid ProviderOne ID number.
  - Complete **PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION** with patient. (Note: expiration date of authorization is six months from signing, unless otherwise indicated.)
  - The patient must sign and date authorization (exemption is not valid without patient's signature).
3. Complete **SECTION 3. PHYSICIAN SECTION:**
  - Enter the name of the physician, the physician's telephone and fax number with area code, and the physician's **SUBOXONE**<sup>®</sup> DEA ID number.
  - The physician is to sign and date this section.
  - The physician is to review exemption limitation with patient.
  - Complete grid. Check one appropriate box for each category.
  - Write a brief clinical justification for the exemption. If you need more space, use additional paper and submit it with the form. Make sure to put the patient name, physician name, and date on the additional paper.
  - Fax completed form to DBHR Certification Policy Manager at (360) 725-2279.
4. Complete **SECTION 4. PHARMACY SECTION:**
  - Print the name of the pharmacy and the pharmacy's telephone and fax number with area code.
  - Payment for the medication is limited to **one** additional six (6) month period of continuous use for the exemption. The medication is limited to a fourteen-day (14-day) supply on each fill.

## 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.

### **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.