COMMUNITY HEALTH PLAN of Washington™

Medication Assisted Treatment
Request For Buprenorphine Monotherapy

Fax: 877-328-9799
Phone: 800-440-1561

SECTION 1: Identification of client and providers

Last name	First name	Middle initial	ProviderOne ID

Address	City	State	ZIP code

Phone number	If release is for information about dependent child(ren), name(s) of dependent child(ren)

Physician name	NPI number	Physician's phone number

Physician's address	City	State	ZIP code

Pharmacy name	Pharmacy address	City	State	ZIP code

SECTION 2: 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 recommendation(s):

- The Health Care Authority (HCA)
- Any Managed Care Organization (MCO) contracted by HCA to provide your medical care
- The above named physician.
- The above named pharmacy

The purpose of this authorization for disclosure is:

- To initiate an authorization to obtain a prescription and coordinate care.

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

Patient signature	Date	Guardian or authorized representative signature (if required)	Date

SECTION 3: To be completed by prescriber only

☐ Patient is pregnant with an estimated delivery date (EDD):_____
Patients approved based on pregnancy will be approved through their EDD. When the client is no longer pregnant, transition to a buprenorphine/naloxone combination product is required for ongoing treatment.

☐ Naloxone Allergy
You must attach chart notes which document a personally observed allergic reaction not attributable to withdrawal (anaphylaxis, angiodema, or hives).

I have read and understand *Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment* https://www.hca.wa.gov/billers-providers/programs-and-services/apple-health-medicaid-drug-coverage-criteria. I will complete form HCA 13-333 Medication Assisted Treatment Patient Status if duration of treatment will be greater than six months.

Prescriber signature	Prescriber specialty	Date

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

This information has been disclosed to you from records protected by Federal confidentiality rules (42 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 medial 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.