COMMUNITY HEALTH PLAN of Washington™

Medication Assisted Treatment
Request For Buprenorphine/Naloxone > 24mg Per Day

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 has been unable to maintain abstinence form other opioids at a dose of 24mg/ day? ☐ Yes ☐ No

If Yes, supporting documentation such as urine drug tests must be submitted with this request.

Has the patient complied with scheduled visits and requests to return for pill counts? ☐ Yes ☐ No

Has the patient complied with provision of urine samples as requested? ☐ Yes ☐ No

Has the patient complied with all other treatment requirements you have set for them? ☐ Yes ☐ No

Urine drug tests show the presence of buprenorphine and its metabolite? ☐ Yes ☐ No

If Yes to all of the above, attach supporting labs, chart notes, and treatment records.

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.