COLORADO STANDARD PRIOR AUTHORIZATION REQUEST FORM- SUD TREATMENT

Member Name:_____ DOB: _____

State ID: _____ ☐RAE 1 ☐RAE 2 ☐RAE 3 ☐RAE 4 ☐RAE 5

☐RAE 6 ☐RAE 7 ☐DHMC ☐CHP

Provider/Facility Name: _____ Today's Date: _____

Provider/Facility NPI: _____

Requestor's Name: _____ Phone Number: _____

Email: _____ Fax:_____

Level of Care Requested:

- ☐ ASAM 2.1 Intensive Outpatient Services
- ☐ ASAM 3.1 Clinically Managed Low-Intensity Residential Services
- ☐ ASAM 3.2WM Clinically Managed Residential Withdrawal Management
- ☐ ASAM 3.3 Clinically Managed Low-Intensity Residential Services
- ☐ ASAM 3.5 Clinically Managed High-Intensity Residential Services
- ☐ ASAM 3.7 Medically Monitored Intensive Inpatient Services
- ☐ ASAM 3.7WM Medically Monitored Withdrawal Management Services

☐ Member not admitted yet

☐ Admitted within 24 hours of this submission

☐ Admitted more than 24 hours of this submission

☐ Admitted and already discharged

Service Start Date: _____ # Days/Visits Requested: _____

ICD-10 Diagnosis Codes (BH & SUD): _____

☐ *Special Connections case*

☐ *Circle Program*

☐ *On current involuntary commitment (IC)*

☐ *On current emergency commitment (EC)*

SUBSTANCE USE

Select all that apply

☐ Alcohol
☐ Barbiturates
☐ Benzodiazepines
☐ Cocaine
☐ LSD
☐ Marijuana
☐ Meth
☐ Opioids
☐ PCP
☐ Other:

As applicable

BAL: _____
UDS:_____
CIWA:_____
COWS: _____
SEWS: _____
MINDS: _____

Vitals (if admitting to 3.2WM, 3.7, & 3.7WM):

Blood pressure: _____
Pulse: _____
Oxygen: _____
Respiration: _____

Current withdrawal symptoms:

☐Headache
☐ Abdominal pain
☐ Seizures (or history of seizures)
☐ Delirium tremens (or history of DTs)
☐ Body aches
☐ Stomach cramps
☐ Nausea/vomiting
☐ Diarrhea
☐ Tremors
☐ Fever
☐ Hallucinations
☐ Cravings
☐ Other:
☐ Gooseflesh
☐ Agitation
☐ Anxiety
☐ Irritability
☐ Yawning
☐ Runny nose

CLINICAL INFORMATION: Please complete below or attach in clinical note/assessment.

SUD TREATMENT HISTORY **Describe other ASAM levels of care utilized in the past 12 months**				
ASAM Level of Care	Name of Provider	Duration	Approx. Dates	Outcome

MEDICATIONS (including MAT) *(attach additional pages as necessary)* ☐**N/A** ☐**Unable to obtain**			
Name of Medication	Dosage	Frequency	Prescriber

ASAM ASSESSMENT: Please complete below or attach in clinical note/assessment.

DIMENSION 1: Acute Intoxication and/or Withdrawal Potential	
☐	No significant withdrawal risk
☐	Minimal risk of severe withdrawal
☐	Not at risk of withdrawal, or minimal/stable withdrawal symptoms present
☐	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2WM
☐	Potential for life threatening withdrawal
☐	Life threatening withdrawal symptoms, including potential or actual seizures, delirium tremens, or other imminent adverse reactions
Provide a brief summary of the member's needs/strengths for Dimension 1. For members with an opioid use disorder, please describe the plan to offer medication-assisted treatment (MAT).	

DIMENSION 2: Biomedical Conditions/Complications	
☐	No biomedical conditions/complications (or not significant to distract from treatment)
☐	Biomedical conditions/complications are stable, concurrent medical monitoring being received
☐	24-hour medical monitoring (but not intensive treatment) is needed
☐	24-hour medical and nursing care, and the full resources of a licensed hospital are needed
Provide a brief summary of the member's needs/strengths for Dimension 2.	

DIMENSION 3: Emotional/Behavioral/Cognitive Conditions	
☐	No emotional, behavioral, or cognitive conditions/complications, or very stable
☐	Mild emotional, behavioral, or cognitive conditions/complications with potential to distract from recovery
☐	Mild or minimal emotional, behavioral, or cognitive conditions/complications that are not distracting to recovery
☐	Mild to moderate emotional, behavioral, or cognitive conditions/complications that require structured interventions to not be a distraction from recovery. Presence of population-specific needs that cannot be met in a lower level of care
☐	Moderate emotional, behavioral, or cognitive conditions/complications that cause repeated inability to control impulses and/or presence of acute symptom instability
☐	Severe emotional, behavioral, or cognitive conditions/complications that require a 24-hour structured and medically monitored setting
☐	Severely unstable emotional, behavioral, or cognitive conditions/complications that require 24-hour psychiatric care in a hospital setting
Provide a brief summary of the member's needs/strengths for Dimension 3.	

DIMENSION 4: Readiness to Change	
☐	Demonstrated readiness for recovery, requires motivating and monitoring strategies to strengthen readiness
☐	Demonstrated variable engagement in treatment, ambivalence, and/or lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment several times per week to promote change
☐	Demonstrated openness to recovery, but needs a structured environment to maintain therapeutic gains
☐	Demonstrated lack of awareness of need for change due to cognitive limitations and addiction. Requires interventions to engage to stay in treatment
☐	Demonstrated marked difficulty with or opposition to treatment with dangerous consequences
☐	Demonstrated high resistance and poor impulse control despite negative consequences. In need of motivating strategies available only in a 24-hour structured setting
Provide a brief summary of the member's needs/strengths for Dimension 4.	

DIMENSION 5: Relapse, Continued Use, or Continued Problem Potential	
☐	Minimal support required to control substance use. In need of support to change behaviors
☐	High likelihood of relapse/continued substance use or addictive behaviors. Requires services several times per week
☐	Understanding of relapse and needs structure to maintain therapeutic gains
☐	Low awareness of relapse and needs interventions only available in a population-specific setting to prevent continued substance use because of cognitive deficits or dysfunction
☐	Presence of psychiatric symptoms, cravings, and/or crises that inhibit the ability to control substance use
☐	Inability to control substance use and requires 24-hour supervision to prevent imminent dangerous consequences
Provide a brief summary of the member's needs/strengths for Dimension 5 (next page).	

DIMENSION 6: Recovery/Living Environment	
☐	Supportive recovery environment and/or adequate skills to cope with stressors
☐	Recovery environment not fully supportive, but able to cope with structure and support
☐	Environment is dangerous, inability to cope outside of a highly structured 24-hour setting
☐	Environment is imminently dangerous, inability to cope outside of a highly structured 24-hour setting
Provide a brief summary of the member's needs/strengths for Dimension 6.	

OPTIONAL: ADDITIONAL CLINICAL INFORMATION

SPECIAL CONNECTIONS ONLY	
Please provide additional information: **Dimension 1:** Is client currently receiving MAT? Is infant in the NICU withdrawing? Are infant's behaviors consistent with substances in the infant's system? **Dimension 2:** Pregnancy status (1st, 2nd, 3rd trimester, post-partum). Pre-natal care status. Any complications during birth? Was infant born with any complications? **Dimension 3:** Assess ACES from parent's life to gauge parenting ability &/or attachment issues. Assess psychiatric medication need and if meds can be taken during pregnancy. Any perinatal anxiety or depression? How is parent responding to birth of infant? **Dimension 4:** Level of preparedness for life/parenting skills to meet needs of infant and all children in mom's custody. Father/partner's engagement in treatment (if using and involved). **Dimension 5:** Parent's reaction to parenting while sober (need for coping skills and structure for successful parenting). Children's reaction to parent taking on parenting responsibilities. **Dimension 6:** Age, custody status/reunification efforts/living arrangement, level of DHS involvement, behavioral/medical needs for existing children. Safe hope/housing access? Level of partner/family support? Is father/partner involved- level of involvement in infant's life, level of use, history of domestic violence.	Attach additional documentation as necessary.

COMPLETE FORM IN ITS ENTIRETY AND SEND TO MEMBER'S RAE ALONG WITH SUPPORTING CLINICAL DOCUMENTATION. INCOMPLETE FORMS WILL CAUSE PROCESSING DELAYS.

RAE	Phone	Fax	Online Submission/Email
Rocky Mountain Health Plans (RAE 1)	970-243-7050	970-257-3986	BHVM@RMHP.org
Northeast Health Partners (RAE 2 Beacon)	888-502-4185	719-538-1439	northeasthealthpartners@beaconhealthoptions.com
Health Colorado (RAE 4 Beacon)	888-502-4189	719-538-1439	healthcolorado@beaconhealthoptions.com
Colorado Access (RAE 3, 5, & DHMC)	800-511-5010	720-744-5130	Behavioral.health@coaccess.com
CCHA (RAE 6 &7)	855-627-4685	844-452-8067	Availity.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form must be filled out completely to be valid.

Member Name:_____ Member ID:_____

I give Colorado Access and the person/organization listed below permission to exchange and share my health information

_____	_____	_____	
Name	Phone number	Fax number	
_____	_____	_____	_____
Address (optional)	City	State	Zip code

Please make selections in the following three (3) sections:

My information may be shared for the following purpose (you must mark a selection):
☑ Care coordination/treatment
☐ To explain benefits and coverage
☐ Legal representation
☐ Grievance and/or appeal representation
☐ At my request
☐ Other _____

By marking one (1) of the boxes below, I give permission to share the following information:
☑ All health records
OR
☐ Only limited information may be shared (select the information you would like to share below).
_____ Billing and claims information/Prior authorizations
_____ Eligibility information
_____ Case management notes/plans
_____ Demographic information
_____ Other - please specify _____

Specific health information will not be shared, unless I select this information below:
_____ HIV/AIDS related information and/or records
_____ Genetic testing information
__✓__ Drug/alcohol diagnosis, treatment and referral information

The information to be shared covers the following dates of service: _____ (all)
My permission will expire one (1) year from the date this authorization is signed, unless I change my permission below: Specific date of expiration: ___/___/___(MM/DD/YY) not to exceed two (2) years.

Authorization Statements

I am voluntarily signing this authorization. I understand that I may refuse to sign this authorization. If I refuse to sign this authorization my health care benefits or payment for my healthcare benefits will not be affected.

I may cancel this authorization at any time. To cancel this authorization, I may call Colorado Access at 855-879-8286, TTY/TDD users call 888-803-4494 or send an email to privacy@coaccess.com. I understand that if I cancel this authorization, it will not affect information that was shared before Colorado Access received my written cancellation.

I understand that if I give Colorado Access permission to share my information, the people or organizations who receive my information may not be required to protect my information.

_____ _____

Signature of the member or personal representative Date

_____ _____

Print the name of the member's personal representative Date

_____

Description of personal representative's authority

Personal Representatives: If you are signing this authorization on behalf of a member, you must include documentation that supports your authority to make health care decisions on behalf of the member.

Minors: Minors 15 years and older may authorize the release of mental health information by signing this form. Minors of any age may authorize the release of health care information related to the treatment of sexually transmitted diseases, including HIV/AIDS, alcohol and/or drug abuse treatment, contraception treatment, and prenatal care services by signing this form.

If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

Si necesita este documento en letra grande, Braille, otros formatos o idiomas, o se lea en voz alta, o necesita otra copia, llame al 800-511-5010. Para TDD/TTY, llame al 888-803-4494. Llame de lunes a viernes, de 8 a.m. a 5 p.m. La llamada es gratis.