

SUBSTANCE USE DISORDER (SUD) AUTHORIZATION REQUEST - ASAM LEVEL 3.7WM

ASAM level 3.7 withdrawal management services *only*

PERSON COMPLETING AND SUBMITTING THIS FORM:

| | | |
|---------------|------|----------------------|
| Name: | | Facility: |
| Phone number: | Fax: | Date form submitted: |

ADMITTING FACILITY (IF KNOWN):

| | |
|----------------|--------------------------------|
| Facility name: | |
| NPI: | Anticipated/Actual admit date: |

MEMBER INFORMATION:

| | |
|--------------|-----------|
| Member name: | |
| DOB: | State ID: |

Select the line of business or organization this request is for:

- Child Health Plan *Plus* offered by Colorado Access (CHP+ HMO) Regional Accountable Entity (RAE) Region 3
 Child Health Plan *Plus* State Managed Care Network (CHP+SMCN) Regional Accountable Entity (RAE) Region 5
 Regional Accountable Entity - Denver Health MCO (RAE DH MCO)

| | |
|-----------------------------|-------------------------------|
| Primary diagnosis (ICD-10): | Secondary diagnosis (ICD-10): |
|-----------------------------|-------------------------------|

SERVICE PRIORITY:

- Prospective (patient not yet admitted for services).
 Concurrent (patient has already started services and needs additional services).

Please complete the following section and attach any relevant clinical information to support this request.

Withdrawal substance(s): for each substance requiring withdrawal management, please list any use information/history that is relevant to the withdrawal risk:

| Substance | Relevant use information/history | |
|--|----------------------------------|--|
| <input type="checkbox"/> Alcohol | | Current blood alcohol level (BAL): |
| <input type="checkbox"/> Heroin | | Positive toxicology screen? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other opiates | | Positive toxicology screen? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Benzodiazepines | | Positive toxicology screen? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Continued on the next page

SUBSTANCE USE DISORDER (SUD) PRIOR AUTHORIZATION REQUEST - ASAM LEVEL 3.7WM

| | | |
|---|--|--|
| <input type="checkbox"/> Other (please specify) | | Positive toxicology screen? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|--|

Biomedical Conditions/Considerations:

- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Body aches | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Stomach cramps | <input type="checkbox"/> Fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures or <input type="checkbox"/> History of seizures | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Sweats/chills | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Delirium tremens or <input type="checkbox"/> History of delirium tremens | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Other (please specify): _____ | | | |

Current vitals:

| | |
|-----------------|--------------|
| Blood pressure: | Oxygen: |
| Pulse: | Respiration: |

Medications:

| |
|---|
| Any withdrawal medications already initiated: |
| Any other medications: |

Mental Health Considerations:

- Suicidal ideation
- Homicidal ideation
- Psychosis/paranoia/grave disability

If yes, please give explanation:

| |
|--|
| |
|--|

After completing this form, send it to us by fax at 720-744-5130 or email it to us at behavioral.health@coaccess.com | 24 hours a day, seven days a week