

COLORADO SUD TREATMENT - STANDARD AUTHORIZATION REQUEST FORM

Please complete this form in its entirety to ensure timely and accurate processing.

Today's Date:	<input type="checkbox"/> In-Network <input type="checkbox"/> Out-of-Network	<input type="checkbox"/> In Person <input type="checkbox"/> Telehealth
Member Name:	DOB:	State ID:
<input type="checkbox"/> RAE 1 <input type="checkbox"/> RAE 2 <input type="checkbox"/> RAE 3 <input type="checkbox"/> RAE 4 <input type="checkbox"/> RAE 5 <input type="checkbox"/> RAE 6 <input type="checkbox"/> RAE 7 <input type="checkbox"/> DHMC <input type="checkbox"/> PRIME <input type="checkbox"/> CHP+		
Provider/Facility Name:		
Provider/Facility Address:		
Provider/Facility NPI:		Provider/Facility TIN:
Requestor's Name:		Phone Number:
Email:		Fax:

Level of Care Requested:	
<input type="checkbox"/> ASAM 2.1 Intensive Outpatient Services	
<input type="checkbox"/> ASAM 2.5 Partial Hospitalization Program	
<input type="checkbox"/> ASAM 3.1 Clinically Managed Low-Intensity Residential Services	
<input type="checkbox"/> ASAM 3.2WWM Clinically Managed Residential Withdrawal Management	
<input type="checkbox"/> ASAM 3.3 Clinically Managed Low-Intensity Residential Services	
<input type="checkbox"/> ASAM 3.5 Clinically Managed High-Intensity Residential Services	
<input type="checkbox"/> ASAM 3.7 Medically Monitored Intensive Inpatient Services	
<input type="checkbox"/> ASAM 3.7WWM Medically Monitored Withdrawal Management Services	
<input type="checkbox"/> Member not admitted yet	<input type="checkbox"/> Admitted more than 24 hours of this submission
<input type="checkbox"/> Admitted within 24 hours of this submission	<input type="checkbox"/> Admitted and already discharged

Admission Date: _____ If Concurrent, what is the last covered day? _____
(date of first service) * If this is a concurrent request, please make sure to include the updated treatment plan and individualized updates.

Days/Visits Requested: _____ Start Date: _____ End Date: _____

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

ICD-10 Diagnosis Codes (all others known): _____

<input type="checkbox"/> Justice Involved Population <i>(Individuals who are under community-based supervision.)</i>	<input type="checkbox"/> Adolescents Special Population <i>(Individuals up to age twenty-one.)</i>	<input type="checkbox"/> Special Connections Population <i>(if yes – please complete section on page 4)</i> <i>Gender-responsive treatment for pregnant and parenting women who are Medicaid eligible in order to maximize the chance of a healthy birth and to provide postpartum treatment services in order to maintain gains made during pregnancy: Only women who were in Special Connections before they delivered are eligible for Special Connections services after they deliver. More information at: https://hcpf.colorado.gov/special-connections</i>
<input type="checkbox"/> Circle Program <i>(Comprehensive community-based residential treatment for individuals with co-occurring substance use and mental health disorders.)</i>	<input type="checkbox"/> Older Adult Special Population <i>(Typically age sixty-five or older, may have Medicare as primary insurance.)</i>	
<input type="checkbox"/> Parenting Population <i>(Parents receiving addiction treatment concurrently with their children who are not eligible for Special Connections.)</i>	<input type="checkbox"/> On current IC <i>(involuntary commitment)</i>	

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SUBSTANCE USE (Select all that apply)				
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Cocaine	<input type="checkbox"/> LSD
<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Opioids	<input type="checkbox"/> PCP	<input type="checkbox"/> Other (please explain):	
Provide the following as applicable:		BAL:	UDS:	CIWA:
COWS:	SEWS:	MINDS:	Pregnant:	Post-Partum:
Vitals <small>(if admitting to 3.2WM, 3.7, & 3.7WM):</small>	Blood pressure:	Pulse:	Oxygen:	Respirations:
Current withdrawal symptoms:				
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Agitation	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Body aches	<input type="checkbox"/> Cravings
<input type="checkbox"/> Delirium tremens <small>(or history of DTs)</small>	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fever	<input type="checkbox"/> Gooseflesh	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Headache	<input type="checkbox"/> Irritability	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Seizures <small>(or history of seizures)</small>
<input type="checkbox"/> Stomach cramps	<input type="checkbox"/> Tremors	<input type="checkbox"/> Yawning	<input type="checkbox"/> Other (please explain):	

CLINICAL INFORMATION: Please complete below and attach 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) <input type="checkbox"/> N/A <input type="checkbox"/> Not taking any medications <input type="checkbox"/> Unable to obtain				
Name of Medication	Medication Start Date	Dosage	Frequency	Prescriber

ASAM ASSESSMENT: Please complete below and attach and supporting clinical note/assessment.

DIMENSION 1: Acute Intoxication and/or Withdrawal Potential	
<input type="checkbox"/>	No significant withdrawal risk
<input type="checkbox"/>	Minimal risk of severe withdrawal
<input type="checkbox"/>	Not at risk of withdrawal, or minimal/stable withdrawal symptoms present
<input type="checkbox"/>	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2WM
<input type="checkbox"/>	Potential for life threatening withdrawal
<input type="checkbox"/>	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).	

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DIMENSION 2: Biomedical Conditions/Complications

<input type="checkbox"/>	No biomedical conditions/complications (or not significant to distract from treatment)
<input type="checkbox"/>	Biomedical conditions/complications are stable, concurrent medical monitoring being received
<input type="checkbox"/>	24-hour medical monitoring (but not intensive treatment) is needed
<input type="checkbox"/>	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. Please make sure to include any medical diagnoses and if there are any complications currently being treated?	

DIMENSION 3: Emotional/Behavioral/Cognitive Conditions

<input type="checkbox"/>	No emotional, behavioral, or cognitive conditions/complications, or very stable
<input type="checkbox"/>	Mild emotional, behavioral, or cognitive conditions/complications with potential to distract from recovery
<input type="checkbox"/>	Mild or minimal emotional, behavioral, or cognitive conditions/complications that are not distracting to recovery
<input type="checkbox"/>	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
<input type="checkbox"/>	Moderate emotional, behavioral, or cognitive conditions/complications that cause repeated inability to control impulses and/or presence of acute symptom instability
<input type="checkbox"/>	Severe emotional, behavioral, or cognitive conditions/complications that require a 24-hour structured and medically monitored setting
<input type="checkbox"/>	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

<input type="checkbox"/>	Demonstrated readiness for recovery, requires motivating and monitoring strategies to strengthen readiness
<input type="checkbox"/>	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
<input type="checkbox"/>	Demonstrated openness to recovery, but needs a structured environment to maintain therapeutic gains
<input type="checkbox"/>	Demonstrated lack of awareness of need for change due to cognitive limitations and addiction. Requires interventions to engage to stay in treatment
<input type="checkbox"/>	Demonstrated marked difficulty with or opposition to treatment with dangerous consequences
<input type="checkbox"/>	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

<input type="checkbox"/>	Minimal support required to control substance use. In need of support to change behaviors
<input type="checkbox"/>	High likelihood of relapse/continued substance use or addictive behaviors. Requires services several times per week
<input type="checkbox"/>	Understanding of relapse and needs structure to maintain therapeutic gains

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<input type="checkbox"/>	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
<input type="checkbox"/>	Presence of psychiatric symptoms, cravings, and/or crises that inhibit the ability to control substance use
<input type="checkbox"/>	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.

DIMENSION 6: Recovery/Living Environment

<input type="checkbox"/>	Supportive recovery environment and/or adequate skills to cope with stressors
<input type="checkbox"/>	Recovery environment not fully supportive, but able to cope with structure and support
<input type="checkbox"/>	Environment is dangerous, inability to cope outside of a highly structured 24-hour setting
<input type="checkbox"/>	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.

ADDITIONAL CLINICAL INFORMATION (as needed)

If you are an out-of-network Provider, please provide rationale of treatment needs.

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/MCO ALONG WITH SUPPORTING CLINICAL DOCUMENTATION. INCOMPLETE FORMS WILL CAUSE PROCESSING DELAYS.

RAE/MCO	Phone	Fax	Online Submission/Email
Rocky Mountain Health Plans (RAE 1), PRIME & CHP+	RAE/PRIME 800-421-6204	970-257-3986	rmhpbhvm@uhc.com
	CHP+ 877-668-5947		
Northeast Health Partners (RAE 2 Carelon)	888-502-4189	719-538-1439	northeasthealthpartners@carelon.com
Health Colorado (RAE 4 Carelon)	888-502-4185	719-538-1439	healthcolorado@carelon.com
Colorado Access (RAE 3, 5, DHMC & CHP+)	800-511-5010	720-744-5130	Behavioral.health@coaccess.com
Colorado Community Health Alliance (RAE 6 & 7)	855-627-4685	844-452-8067	Availity.com