PRIOR AUTHORIZATION FORM: Substance Use Disorder (SUD) Residential Treatment or Partial Hospitalization Program Initial Request

This form is for SUD Residential Treatment or Partial Hospitalization Program stays. It is to be completed prior to admission into residential or partial hospitalization facilities. When a member is stepping down directly from an inpatient hospital or ARF stay, the request for authorization must be received within 24 hours hours of the discharge. Clinical for concurrent review must be received no later than 24 hours prior to the last covered day. ALL QUESTIONS MUST BE ANSWERED.

FAX this form to 1-855-407-5688

RTC PHP

Member Name: Today's Date:

DOB: **ID:** Time:

Facility Name:

NPI/TIN: Physician Order Date: Time:

UR Name:

Phone:

Does member have other insurance? Yes No

If yes, Name:

Address:

Phone:

If member is a minor, guardian/CPS caseworker name:

Phone:

Date ROI requested from family/guardian/proxy (must attach a copy):

Voluntary or Involuntary (Marchman Act/Ex-parte) (must attach a copy):

If this is NOT a planned admission, **STOP! YOU MUST CALL IN!**

Pregnant? Yes No How many weeks?

OB Name:

Phone:

Specific/comprehensive reason for admission required: (hx of OD/SI/HI/H/O failed TX):

ASAM criteria level:

Stage of change:

Admitting UDS/BAL:

Motivation for change:

Admitting DX (and any additional):

CIWA/COWS/ withdrawal SX/vitals:

Meds initiated (date/time/dose/frequency):

List all current meds & compliance:

Current medical concerns/allergies/precautions:

Cultural considerations (language, religious, sexual orientation)

Anticipated LOS:

Attending Doctor Name:

Phone:

HISTORY

CD use (substances/age first used/amount/frequency/last use):

CD treatment Hx (when, where, duration, outcomes, MAT):

Triggers for use, longest sobriety:

Sober support (names/phone):

H/O IP psych admissions and dx (note prior suicide/homicide attempts/how):

H/O of psychiatric meds/compliance/outcome:

H/O trauma:

H/O OP treatment/compliance:

H/O education/employment/legal:

H/O family SUD or MH:

TREATMENT PLAN

Provide goals in **SMART** format.

Be **S**pecific, noting each goal. How will the goal be **M**easured, or monitored in a quantifiable way? It must be **A**ttainable and **R**ealistic for the individual's circumstances. It must be **T**ime-specific, so the member knows how long reaching the goal should take.

DISCHARGE PLAN

(Must provide specific updated information at each review. Attach supporting documentation below.)

DCP/CM/SW Name:

Phone:

UR Name:

Phone:

Number of requested days: