Substance Use Disorder Treatment

CareOregon Advantage

Authorization Request

Please complete all fields below as indicated, select the appropriate level of care, and attach relevant clinical documentation. Please type directly onto the form and please make sure the request form is complete and legible. Providers must fax all authorization request forms and attachments to 503-416-3713.

Date of request: _____

Member Information

Last name: _____ First name: _____ MI: _____

DOB: _____ Member OHP ID#:_____

Provider Information

Delivering Agency		**Referring Agency**	
Contact person:		Contact person:	
Contact phone:		Contact phone:	
Contact email:		Contact email:	
Contact fax:		Contact fax:	

Admit date: _____ Discharge date (if applicable): _____

Expected duration of services: _____

DSM-5 substance use disorder diagnosis: _____

DSM-5 substance use disorder diagnosis severity specifier (e.g., mild, moderate, severe): _____

DSM-5 covered mental health diagnosis on the prioritized list (required for dual diagnosis treatment): _____

_____

Indicate Authorization Request Type

○ Adult ○ Adolescent ○ Parent with child ○ Member is pregnant ○ Dual diagnosis residential

○ Initial authorization request -OR- ○ Continued stay request (enter initial admit date): _____

Number of days requested (for either initial or continued stay): _____

Continued >>

CareOregon Advantage

Select ONE of the following ASAM levels of care (enter codes and units if prompted)

- ○ **Assessment**
- ○ **Medication-Assisted Treatment Opioid Treatment Program – MAT OTP**
- ○ **Level 1** : Outpatient services
  Adult: less than nine hours of service per week _____ Adolescent: less than six hours of service per week: _____ hours
- ○ **Level 2.1** : Intensive outpatient services
  Adult: 9-19 hours of service per week _____ Adolescent: 6-19 hours of service per week _____ hours
- ○ **Level 2.5:** Partial hospitalization: 20 or more hours of service per week
- ○ **Level 3.1:** Residential treatment: Clinically managed low-intensity services with at least five hours of clinical service per week
- ○ **Level 3.5:** Residential treatment: Clinically managed high-intensity services with 24-hour care trained counselors
- ○ **Level 3.7:** Residential treatment: Medically monitored intensive services with 24-hour nursing care and physician availability
- ○ **Level 3.2:** Withdrawal management: Clinically managed withdrawal requiring 24-hour support
- ○ **Level 3.7:** Withdrawal management: Severe medically monitored withdrawal requiring 24-hour nursing care and physician as needed
- ○ **Level 4.0:** Withdrawal management: Severe, unstable withdrawal requiring daily physician care

Please include the following documentation for all authorization requests:

Current substance use assessment that includes:

- Clinical justification for the DSM-5 diagnosis(es).
- Explanation of the medical and clinical need for the services.

ASAM assessment that includes:

- Individualized assessment across all six dimensions with risk ratings.
- Summary formulation justifying recommended level of care.
- For continued stay requests: Include updated ASAM assessment.

Service plan that includes:

- Individualized plan based on the risks and needs identified in the assessment.
- Specific and measurable goals or objectives individualized to meet the assessed needs of the patient.
- Specific services and supports to be provided to include frequency and duration (e.g., individual counseling, group counseling, case management, peer support, etc.).
- For continued stay requests: Include progress notes and updated service plan.

*__Dual diagnosis residential treatment authorization:__

Include mental health assessment and mental health service plan individualized to the member's specific risks and needs.

Additional Comments

_____

_____

_____