OHIO URINE DRUG SCREEN PRIOR AUTHORIZATION (PA) REQUEST FORM

The Clinical Advisory Group of the Ohio Department of Mental Health and Addiction Services established broad guidelines to appropriate clinical use of urine drug screening for patients with a substance use disorder. These guidelines took into account ease of access for patients by eliminating barriers to care, as well as account for patient safety, acuity, risk of relapse/overdose, level of care, and sustained abstinence.

Date of Request: _____

Patient Information

Last Name: _____First Name: _____
DOB: _____ Member ID: _____ Patient phone # _____

Provider Information

1. Ordering Provider Name: _____
   Tax ID: _____NPI: _____Phone _____
   Fax:_____
2. Service Provider (Laboratory/Facility) Name: _____
   Tax ID: _____NPI: _____Phone _____
   Fax:_____

Supporting Documentation - ***Supporting documents must be attached (including current medication list including current MAT, OTC meds, supplements that may interfere with testing; patient's drug(s) of choice; ICD-10 Diagnosis code(s); drug testing history with results)***

Reason for request: (Check all that apply):
□ Addiction Treatment □ Chronic pain management □ Other _____
Patient's current phase of care: □ Induction □ Stabilization □ Maintenance □ Long term maintenance □ Relapse[1]
Patient's current ASAM Level of Care: _____; □ not yet determined
List date of testing if different than the date of this PA request: _____

1. Presumptive (select one): □ 80305 □ 80306 □ 80307
2. Confirmatory – include type of test (s): _____

For Patients with Chronic Pain on Opioid Therapy - Provide results of most recent screening.

Additional Clinical Information

Is patient currently pregnant? □ Yes □ No
If suspected diversion, list risk factors: _____
Has patient been adherent to MAT over past 3 months: □ Yes □ No
If no, □ All of time □ Most of time □ Erratic □ Poor □ Unknown
Has medication administration been observed: □ Yes □ No
Provide any additional information that is needed to be considered with this completed form.

Form completed by: _____ Phone number:_____

[1] OHIO URINE DRUG SCREEN PRIOR AUTHORIZATION (PA) REQUEST FORM T0977

[1] Definition of Relapse: (ASAM National Practice Guideline (2015) A process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors.