Screening Being Requested:
Presumptive (select one): ☐ 80305 ☐ 80306 ☐ 80307
Confirmatory (select one): ☐ G0480 ☐ G0481 ☐ G0482 ☐ G0483

Date of Request: Click or tap to enter a date.
Form Completed By: Click or tap here to enter text.
Phone Number: Click or tap here to enter text.

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 consider 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.

Patient Information

Last Name: Click or tap here to enter text. First Name: Click or tap here to enter text.

DOB:Click or tap to enter a date. Member ID: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

Provider Information

1. **Ordering Provider**
   a. Name: Click or tap here to enter text.
   b. Tax ID: Click or tap here to enter text.
   c. NPI: Click or tap here to enter text.
   d. Phone: Click or tap here to enter text.
   e. Fax: Click or tap here to enter text.

2. **Service Provider (Laboratory/Facility)**
   a. Name: Click or tap here to enter text.
   b. Tax ID: Click or tap here to enter text.
   c. NPI: Click or tap here to enter text.
   d. Phone: Click or tap here to enter text.
   e. Fax: Click or tap here to enter text.

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)*

List date of testing, if different than the date of this PA request: Click or tap to enter a date.

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: Click or tap here to enter text. ☐ TBD

For Patients with Chronic Pain on Opioid Therapy: Attach results of most recent screening.

Additional Clinical Information:

1. Is patient currently pregnant? ☐ Yes ☐ No
2. If suspected diversion, list risk factors: Click or tap here to enter text.
3. Has patient been adherent to MAT over past 3 months: ☐ Yes ☐ No
   a. If no, ☐ All of time ☐ Most of time ☐ Erratic ☐ Poor ☐ Unknown
4. Has medication administration been observed: ☐ Yes ☐ No

[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.