Phone: **1-800-488-0134**

Fax: 1-888-752-0012

URINE DRUG SCREEN PRIOR AUTHORIZATION REQUEST FORM

☐ Routine ☐ Urgent

PATIENT INFORMATION

Date of Request _____Member ID # _____

Member's Last Name _____First Name _____

Member Address _____

DOB _____Phone Number _____

Please attach all supporting clinical documentation as outlined in the UDT Medical Policy posted on **CareSource.com.**

Please check the specific reason for the request:

____Opioid treatment program _____Addiction treatment

____Chronic pain management _____ Other: _____

Please check the phase the member is currently in:

____ Induction _____Stabilization

____ Maintenance _____ Long term maintenance

Please complete one line for each test type being **requested**:

Test type	Codes for each test	Date requested
Presumptive/qualitative		
Presumptive/qualitative		
Presumptive/qualitative		
Presumptive/qualitative		
Definitive/quantitative		
Definitive/quantitative		
Definitive/quantitative		
Definitive/quantitative		

SUPPORT FOR REQUESTED TESTING

Ordering Provider Name: _____

Tax ID_____NPI_____

Phone _____ Fax_____

Ordering Provider Address _____

Service Provider (Laboratory or Facility) Full Name _____

Address: _____

Phone: _____ Fax: _____

Tax ID: _____ NPI : _____

Current ASAM Level of Care (please check below if applicable):_

☐ 0.5 Early Intervention

☐ 2.1 Intensive OP Service

☐ 2.5 Partial Hospitalization

☐ 3.1 Low Intensity SUD Residential

☐ 3.3 Clinically Managed Population Specific High Intensity SUD Residential

☐ 3.5 Clinically Managed Medium Intensity Residential

☐ 3.7 Medically Monitored High Intensity Inpatient Services

☐ 4.0 Medically Managee Intensive Inpatient Services

_____

List drug (s) of choice: _____

Has there been recent clinical evidence of diversion? _____

How long has the patient been receiving treatment?_____

Please provide the results of most recent SOAPP-R or ORT screening:

_____

Date of last overdose requiring Narcan (if applicable): _____

Unexpected result trends in recent drug testing:

_____

_____

What clinical interventions have been made to address the issues above other than drug testing for unexpected drug testing results? _____

How will the requested urine drug testing influence the treatment plan?_____

_____

For members with chronic pain & a controlled substance prescribed, please complete the following table or _____ N/A

Diagnosis	**Prescribed scheduled medication(s)**	**If controlled substance, reason**

Prescribed MAT- please complete the table below or _____ N/A

Medication	**Is member adherent to MAT?**	**If member receives counseling or other services, please list**
	Yes No	
	Yes No	
	Yes No	
	Yes No	
	Yes No	

TEST HISTORY

Please complete one line for each test type that have been **completed** (note: this is not what you are requesting authorization for currently)

Test type Circle test type	Codes for each test	Date completed	Results
Presumptive/qualitative			
Presumptive/qualitative			
Presumptive/qualitative			
Presumptive/qualitative			
Presumptive/qualitative			
Presumptive/qualitative			
Presumptive/qualitative			
Presumptive/qualitative			

Presumptive/qualitative			
Presumptive/qualitative			
Presumptive/qualitative			
Presumptive/qualitative			
Definitive/quantitative			
Definitive/quantitative			
Definitive/quantitative			
Definitive/quantitative			
Definitive/quantitative			
Definitive/quantitative			
Definitive/quantitative			
Definitive/quantitative			
Definitive/quantitative			
Definitive/quantitative			
Definitive/quantitative			

This Form Completed By: _____ Title: _____