

## 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<sup>1</sup>

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: \_\_\_\_\_

<sup>1</sup> OHIO URINE DRUG SCREEN PRIOR AUTHORIZATION (PA) REQUEST FORM T0977

<sup>1</sup> 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.