

**COLORADO SUD TREATMENT - STANDARD AUTHORIZATION REQUEST FORM**

Please complete this form in its entirety to ensure timely and accurate processing.

Today's Date:	<input type="checkbox"/> In-Network <input type="checkbox"/> Out-of-Network	<input type="checkbox"/> In Person <input type="checkbox"/> Telehealth
Member Name:	DOB:	State ID:
<input type="checkbox"/> RAE 1 <input type="checkbox"/> RAE 2 <input type="checkbox"/> RAE 3 <input type="checkbox"/> RAE 4 <input type="checkbox"/> RAE 5 <input type="checkbox"/> RAE 6 <input type="checkbox"/> RAE 7 <input type="checkbox"/> DHMC <input type="checkbox"/> PRIME <input type="checkbox"/> CHP+		
Provider/Facility Name:		
Provider/Facility Address:		
Provider/Facility NPI:	Provider/Facility TIN:	
Requestor's Name:	Phone Number:	
Email:	Fax:	

Level of Care Requested:	
<input type="checkbox"/> ASAM 2.1 Intensive Outpatient Services	
<input type="checkbox"/> ASAM 2.5 Partial Hospitalization Program	
<input type="checkbox"/> ASAM 3.1 Clinically Managed Low-Intensity Residential Services	
<input type="checkbox"/> ASAM 3.2WWM Clinically Managed Residential Withdrawal Management	
<input type="checkbox"/> ASAM 3.3 Clinically Managed Low-Intensity Residential Services	
<input type="checkbox"/> ASAM 3.5 Clinically Managed High-Intensity Residential Services	
<input type="checkbox"/> ASAM 3.7 Medically Monitored Intensive Inpatient Services	
<input type="checkbox"/> ASAM 3.7WWM Medically Monitored Withdrawal Management Services	
<input type="checkbox"/> Member not admitted yet	<input type="checkbox"/> Admitted more than 24 hours of this submission
<input type="checkbox"/> Admitted within 24 hours of this submission	<input type="checkbox"/> Admitted and already discharged

Admission Date: \_\_\_\_\_ If Concurrent, what is the last covered day? \_\_\_\_\_  
(date of first service) \* If this is a concurrent request, please make sure to include the updated treatment plan and individualized updates.

# Days/Visits Requested: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

ICD-10 Diagnosis Codes (BH & SUD): \_\_\_\_\_

ICD-10 Diagnosis Codes (all others known): \_\_\_\_\_

<input type="checkbox"/> <b>Justice Involved Population</b> <i>(Individuals who are under community-based supervision.)</i>	<input type="checkbox"/> <b>Adolescents Special Population</b> <i>(Individuals up to age twenty-one.)</i>	<input type="checkbox"/> <b>Special Connections Population</b> <i>(if yes – please complete section on page 4) Gender-responsive treatment for pregnant and parenting women who are Medicaid eligible in order to maximize the chance of a healthy birth and to provide postpartum treatment services in order to maintain gains made during pregnancy: Only women who were in Special Connections before they delivered are eligible for Special Connections services after they deliver. More information at: <a href="https://hcpf.colorado.gov/special-connections">https://hcpf.colorado.gov/special-connections</a></i>
<input type="checkbox"/> <b>Circle Program</b> <i>(Comprehensive community-based residential treatment for individuals with co-occurring substance use and mental health disorders.)</i>	<input type="checkbox"/> <b>Older Adult Special Population</b> <i>(Typically age sixty-five or older, may have Medicare as primary insurance.)</i>	
<input type="checkbox"/> <b>Parenting Population</b> <i>(Parents receiving addiction treatment concurrently with their children who are not eligible for Special Connections.)</i>	<input type="checkbox"/> <b>On current IC</b> <i>(involuntary commitment)</i> <input type="checkbox"/> <b>On current EC</b> <i>(emergency commitment)</i>	

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<b>SUBSTANCE USE</b> (Select all that apply)				
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Cocaine	<input type="checkbox"/> LSD
<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Opioids	<input type="checkbox"/> PCP	<input type="checkbox"/> Other (please explain):	
<b>Provide the following as applicable:</b>		BAL:	UDS:	CIWA:
COWS:	SEWS:	MINDS:	Pregnant:	Post-Partum:
<b>Vitals</b> <small>(if admitting to 3.2WM, 3.7, &amp; 3.7WM):</small>	Blood pressure:	Pulse:	Oxygen:	Respirations:
Current withdrawal symptoms:				
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Agitation	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Body aches	<input type="checkbox"/> Cravings
<input type="checkbox"/> Delirium tremens <small>(or history of DTs)</small>	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fever	<input type="checkbox"/> Gooseflesh	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Headache	<input type="checkbox"/> Irritability	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Seizures <small>(or history of seizures)</small>
<input type="checkbox"/> Stomach cramps	<input type="checkbox"/> Tremors	<input type="checkbox"/> Yawning	<input type="checkbox"/> Other (please explain):	

**CLINICAL INFORMATION: Please complete below and attach clinical note/assessment.**

<b>SUD TREATMENT HISTORY</b> Describe other ASAM levels of care utilized in the past 12 months				
ASAM Level of Care	Name of Provider	Duration	Approx. Dates	Outcome

<b>MEDICATIONS (including MAT)</b> (attach additional pages as necessary) <input type="checkbox"/> N/A <input type="checkbox"/> Not taking any medications <input type="checkbox"/> Unable to obtain				
Name of Medication	Medication Start Date	Dosage	Frequency	Prescriber

**ASAM ASSESSMENT: Please complete below and attach and supporting clinical note/assessment.**

<b>DIMENSION 1: Acute Intoxication and/or Withdrawal Potential</b>	
<input type="checkbox"/>	No significant withdrawal risk
<input type="checkbox"/>	Minimal risk of severe withdrawal
<input type="checkbox"/>	Not at risk of withdrawal, or minimal/stable withdrawal symptoms present
<input type="checkbox"/>	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2WM
<input type="checkbox"/>	Potential for life threatening withdrawal
<input type="checkbox"/>	Life threatening withdrawal symptoms, including potential or actual seizures, delirium tremens, or other imminent adverse reactions
Provide a brief summary of the member's needs/strengths for Dimension 1. For members with an opioid use disorder, please describe the plan to offer medication-assisted treatment (MAT).	

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**DIMENSION 2: Biomedical Conditions/Complications**

<input type="checkbox"/>	No biomedical conditions/complications (or not significant to distract from treatment)
<input type="checkbox"/>	Biomedical conditions/complications are stable, concurrent medical monitoring being received
<input type="checkbox"/>	24-hour medical monitoring (but not intensive treatment) is needed
<input type="checkbox"/>	24-hour medical and nursing care, and the full resources of a licensed hospital are needed
Provide a brief summary of the member's needs/strengths for Dimension 2. Please make sure to include any medical diagnoses and if there are any complications currently being treated?	

**DIMENSION 3: Emotional/Behavioral/Cognitive Conditions**

<input type="checkbox"/>	No emotional, behavioral, or cognitive conditions/complications, or very stable
<input type="checkbox"/>	Mild emotional, behavioral, or cognitive conditions/complications with potential to distract from recovery
<input type="checkbox"/>	Mild or minimal emotional, behavioral, or cognitive conditions/complications that are not distracting to recovery
<input type="checkbox"/>	Mild to moderate emotional, behavioral, or cognitive conditions/complications that require structured interventions to not be a distraction from recovery. Presence of population-specific needs that cannot be met in a lower level of care
<input type="checkbox"/>	Moderate emotional, behavioral, or cognitive conditions/complications that cause repeated inability to control impulses and/or presence of acute symptom instability
<input type="checkbox"/>	Severe emotional, behavioral, or cognitive conditions/complications that require a 24-hour structured and medically monitored setting
<input type="checkbox"/>	Severely unstable emotional, behavioral, or cognitive conditions/complications that require 24-hour psychiatric care in a hospital setting
Provide a brief summary of the member's needs/strengths for Dimension 3.	

**DIMENSION 4: Readiness to Change**

<input type="checkbox"/>	Demonstrated readiness for recovery, requires motivating and monitoring strategies to strengthen readiness
<input type="checkbox"/>	Demonstrated variable engagement in treatment, ambivalence, and/or lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment several times per week to promote change
<input type="checkbox"/>	Demonstrated openness to recovery, but needs a structured environment to maintain therapeutic gains
<input type="checkbox"/>	Demonstrated lack of awareness of need for change due to cognitive limitations and addiction. Requires interventions to engage to stay in treatment
<input type="checkbox"/>	Demonstrated marked difficulty with or opposition to treatment with dangerous consequences
<input type="checkbox"/>	Demonstrated high resistance and poor impulse control despite negative consequences. In need of motivating strategies available only in a 24-hour structured setting
Provide a brief summary of the member's needs/strengths for Dimension 4.	

**DIMENSION 5: Relapse, Continued Use, or Continued Problem Potential**

<input type="checkbox"/>	Minimal support required to control substance use. In need of support to change behaviors
<input type="checkbox"/>	High likelihood of relapse/continued substance use or addictive behaviors. Requires services several times per week
<input type="checkbox"/>	Understanding of relapse and needs structure to maintain therapeutic gains

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<input type="checkbox"/>	Low awareness of relapse and needs interventions only available in a population-specific setting to prevent continued substance use because of cognitive deficits or dysfunction
<input type="checkbox"/>	Presence of psychiatric symptoms, cravings, and/or crises that inhibit the ability to control substance use
<input type="checkbox"/>	Inability to control substance use and requires 24-hour supervision to prevent imminent dangerous consequences

Provide a brief summary of the member's needs/strengths for Dimension 5.

**DIMENSION 6: Recovery/Living Environment**

<input type="checkbox"/>	Supportive recovery environment and/or adequate skills to cope with stressors
<input type="checkbox"/>	Recovery environment not fully supportive, but able to cope with structure and support
<input type="checkbox"/>	Environment is dangerous, inability to cope outside of a highly structured 24-hour setting
<input type="checkbox"/>	Environment is imminently dangerous, inability to cope outside of a highly structured 24-hour setting

Provide a brief summary of the member's needs/strengths for Dimension 6.

**ADDITIONAL CLINICAL INFORMATION** (as needed)

**If you are an out-of-network Provider, please provide rationale of treatment needs.**

**SPECIAL CONNECTIONS ONLY**

Please provide additional information:

**Dimension 1:** Is client currently receiving MAT? Is infant in the NICU withdrawing? Are infant's behaviors consistent with substances in the infant's system?

**Dimension 2:** Pregnancy status (1st, 2nd, 3rd trimester, post- partum). Pre-natal care status. Any complications during birth? Was infant born with any complications?

**Dimension 3:** Assess ACES from parent's life to gauge parenting ability &/or attachment issues. Assess psychiatric medication need and if meds can be taken during pregnancy. Any perinatal anxiety or depression? How is parent responding to birth of infant?

**Dimension 4:** Level of preparedness for life/parenting skills to meet needs of infant and all children in mom's custody. Father/partner's engagement in treatment (if using and involved).

**Dimension 5:** Parent's reaction to parenting while sober (need for coping skills and structure for successful parenting). Children's reaction to parent taking on parenting responsibilities.

**Dimension 6:** Age, custody status/reunification efforts/living arrangement, level of DHS involvement, behavioral/medical needs for existing children. Safe hope/housing access? Level of partner/family support? Is father/partner involved-level of involvement in infant's life, level of use, history of domestic violence.

**Attach additional documentation as necessary.**

**COMPLETE FORM IN ITS ENTIRETY AND SEND TO MEMBER'S RAE/MCO ALONG WITH SUPPORTING CLINICAL DOCUMENTATION. INCOMPLETE FORMS WILL CAUSE PROCESSING DELAYS.**

RAE/MCO	Phone	Fax	Online Submission/Email
Rocky Mountain Health Plans (RAE 1), PRIME & CHP+	RAE/PRIME 800-421-6204	970-257-3986	rmhpbhvm@uhc.com
	CHP+ 877-668-5947		
Northeast Health Partners (RAE 2 Carelon)	888-502-4189	719-538-1439	northeasthealthpartners@carelon.com
Health Colorado (RAE 4 Carelon)	888-502-4185	719-538-1439	healthcolorado@carelon.com
Colorado Access (RAE 3, 5, DHMC & CHP+)	800-511-5010	720-744-5130	Behavioral.health@coaccess.com
Colorado Community Health Alliance (RAE 6 & 7)	855-627-4685	844-452-8067	Availity.com