|  |  |
| --- | --- |
| **Screening Being Requested:** | **Date of Request:** Click or tap to enter a date. |
| Presumptive (select one): [ ]  80305 [ ]  80306 [ ]  80307 | **Form Completed By:** Click or tap here to enter text.  |
| Confirmatory (select one): [ ]  G0480 [ ]  G0481 [ ]  G0482 [ ]  G0483  | **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**
	1. Name: Click or tap here to enter text.
	2. Tax ID: Click or tap here to enter text.
	3. NPI: Click or tap here to enter text.
	4. Phone: Click or tap here to enter text.
	5. Fax: Click or tap here to enter text.
2. **Service Provider (Laboratory/Facility)**
	1. Name: Click or tap here to enter text.
	2. Tax ID: Click or tap here to enter text.
	3. NPI: Click or tap here to enter text.
	4. Phone: Click or tap here to enter text.
	5. 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]](#footnote-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.

1. Has patient been adherent to MAT over past 3 months: [ ]  Yes [ ]  No
	1. If no, [ ]  All of time [ ]  Most of time [ ]  Erratic [ ]  Poor [ ]  Unknown
2. 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. [↑](#footnote-ref-1)