AmeriHealth Caritas™
Delaware

Behavioral Health Substance Use Disorder (SUD) Prior Authorization Form

(All substance use disorder services Level 2.1 and higher)

Submit to: Behavioral Health Utilization Management
Fax: 1-877-234-4273
For assistance, please call: 1-855-301-5512

Please note: Authorization is based on medical necessity. Incomplete or illegible forms will delay processing. Please provide all pertinent clinical information, including clinical assessment, DE-ASAM, and treatment plans.

Date:	Date of admission or service start date:	Estimated length of stay:
☐ Notification only	☐ Precertification	☐ Continued stay

REQUESTED SERVICE

☐ SUD acute detox in a hospital setting Service or revenue code: Date of discharge:	☐ Level 3.7: Medically monitored intensive inpatient Service code with modifier(s):	☐ Level 3.7-WM: Medically monitored inpatient withdrawal management Service code with modifier(s):
☐ Level 3.5: Clinically managed high-intensity residential Service code with modifier(s):	☐ Level 3.3: Clinically managed high-intensity residential (pop spec) Service code with modifier(s):	☐ Level 3.2-WM: Clinically managed residential withdrawal management Service code with modifier(s):
☐ Level 3.1: Low-intensity residential Service code with modifier(s):	☐ Level 2-WM: Ambulatory withdrawal management Service code with modifier(s):	☐ SUD peer support services Service code with modifier(s):
☐ Level 2.5: SUD partial hospitalization Service code with modifier(s): Days per week: Total hours per week:	☐ Level 2.1: SUD intensive outpatient services Service code with modifier(s): Days per week: Total hours per week:	

MEMBER INFORMATION

Name (last, first, MI):		
Date of birth:	Phone number:	Eligibility ID number:
Address:		
Emergency contact:		
Relationship:	Phone number:	
If dependent adult, legal guardian:	Phone number:	

Is this member currently in the PROMISE program? ☐ Yes ☐ No

Should the member be evaluated for the PROMISE program? ☐ Yes ☐ No

PROVIDER INFORMATION

Facility name:			
Facility address:			
Facility NPI/tax ID:	Facility phone number:	Facility fax number:	
UM review contact name:	Attending physician:	NPI/tax ID:	

DIAGNOSES

Primary diagnosis:	Secondary diagnosis:	Tertiary diagnosis:

MEDICATIONS

Home medications, if known, including dosages and prescriber (e.g., PCP or psychiatrist):

Name of current treating psychiatrist, if any:	Date last seen:

Medication name	Dosage	Frequency	Date of last change, if applicable	Type of change
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New

Additional information, if applicable:

CURRENT RISK AND LETHALITY

Suicidal: ☐ No ☐ Yes — please answer questions below.

Active recurrent thoughts: ☐ Yes ☐ No	Making threats: ☐ Yes ☐ No	Plan: ☐ Yes ☐ No

Available means: ☐ No ☐ Yes — please explain:

Command hallucinations: ☐ No ☐ Yes — please explain:

History of suicide attempts: ☐ No ☐ Yes — please explain:

Homicidal thoughts: ☐ No ☐ Yes — please explain:

Active recurrent thoughts: ☐ Yes ☐ No	Making threats: ☐ Yes ☐ No	Plan: ☐ Yes ☐ No

Available means: ☐ No ☐ Yes — please explain:

Command hallucinations: ☐ No ☐ Yes — please explain:

History of homicide attempts: ☐ No ☐ Yes — please explain:

Assault or violence: ☐ No ☐ Yes — please explain:

History of assault or violence: ☐ No ☐ Yes — please explain:

MENTAL STATUS EXAM

(Including appearance, eye contact, speech, motor activity, thought process and content, orientation, mood, affect, and hallucinations)

PRESENTING PROBLEM/CURRENT CLINICAL

Current clinical (SI, HI, psychosis, mood or affect, sleep, appetite, withdrawal symptoms, chronic SUD):

Describe member's functioning:

☐ Activities of daily living (ADLs):

☐ Social settings:

☐ Education and occupation:

☐ Current living environment:

☐ Indicate the recommendations of the member's assessment or evaluation and treatment plan:

TREATMENT HISTORY AND/OR CURRENT TREATMENT PARTICIPATION

How long has the member experienced mental illness and/or an SUD?

☐ Previous treatment — please provide specifics:

☐ Current treatment — please provide specifics:

☐ No previous or current treatment noted

DIMENSION RATING (none, stable, low, moderate, severe)	**CURRENT ASAM DIMENSIONS ARE REQUIRED**			
Dimension 1: acute intoxication and/ or withdrawal potential Rating:	Substances used (pattern, route, last used):	Toxicology screen completed? ☐ Yes ☐ No If yes, results:	History of withdrawal symptoms: ☐ Yes ☐ No	Current withdrawal symptoms:
Dimension 2: biomedical conditions and the complications Rating:	Vital signs:	Is the member under a doctor's care? ☐ Yes ☐ No If yes, known medical condition:	History of withdrawal seizures? ☐ Yes ☐ No	Any additional pertinent information:
Dimension 3: emotional, behavioral, or cognitive conditions and complications Rating:	Mental health diagnosis:	Cognitive limits? ☐ Yes ☐ No	Current medications and dosages, if not listed on page 2	Current risk factors (SI, HI, and psychotic symptoms):
Dimension 4: readiness to change Rating:	Awareness and commitment to change:	Internal or external motivation:	Stage of change, if known:	Legal problems and probation officer:
Dimension 5: relapse, continued use, or continued problem potential Rating:	Relapse prevention skills:	Current assessed relapse risk level: ☐ High ☐ Moderate ☐ Low	Longest period of sobriety:	Any additional pertinent information:
Dimension 6: recovery and living environment Rating:	Living situation:	Sober support system: ☐ Yes ☐ No If yes, whom:	Attendance at support group: ☐ Yes ☐ No	Issues that impede recovery:

DISCHARGE PLANNING	
Discharge planner name:	
Phone number:	Fax number:
Place of residence upon discharge:	
Address:	
Treatment setting and services upon discharge:	
Provider of services, if known:	
Has a post-discharge seven-day follow-up aftercare appointment been scheduled? ☐ Yes (complete below) Provider name: Date and time of appointment: ☐ No — please explain:	
Identify collaboration needs. Please indicate if collaboration is needed with any of the below, including contact name and phone number:	
☐ PROMISE program: ☐ Child or adult protective agency: ☐ Group home: ☐ Nursing or nursing home facility: ☐ Residential program: ☐ Jail, prison, or court system: ☐ LTSS or waiver programs: ☐ Other:	

Provider signature:
Date: