

4. Does the patient present evidence of, or is he/she at risk of a serious or chronic medical condition(s) that may be exacerbated by a return to illicit opiate use. If yes, please list condition(s).

5a. Does the patient have a severe and persistent mental illness? If yes, please provide the pertinent medical history and DSM V diagnosis.

5b. Is an emotional, behavioral, or cognitive disorder (including a severe and persistent mental illness, as described above) currently being managed? If yes, please describe how it may impact treatment and how it will be addressed.

Please include a detailed Individualized Service Plan (ISP) that addresses the frequency and scope of counseling and plans for other measureable improvements.

By checking this box, I, the Medical Director, attest to the fact that this patient meets all 6 ASAM criteria

By checking this box, I, the Medical Director, attest to the fact that this MaineCare member has signed a Release of Information allowing my agency to communicate with the member's primary care provider regarding the member's health information, including, but not limited to, opioid addiction treatment. (Please document if the member has refused to sign the release)

PHYSICIAN RECOMMENDATION

Based on the above information, this patient meets the criteria for medical necessity validating the need for them to continue receiving services in a methadone treatment program.

Physician name _____

Physician signature

Date