

# REQUEST FOR CONTINUED METHADONE TREATMENT

ISP Attached

\*This form must be completed for continued methadone treatment after a member has been in treatment for 24 months.

## PATIENT INFORMATION

<b>Patient's Last Name:</b>	<b>First:</b>	<b>Middle:</b>	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	<b>TREATING PROVIDER NAME</b>
<b>TREATMENT START DATE</b>	<b>TODAY'S DATE</b>		<b>PRIMARY CARE PROVIDER</b>		
____ / ____ / ____	____ / ____ / ____				

## MANDATORY INCLUSION CRITERIA

Is the patient pregnant? If yes, what is her due date? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is the patient court-ordered to remain in treatment? (If yes, please attach supporting documentation.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does the patient have one or more children, age 3 or younger, who primarily reside with the patient or for whom this patient is the sole responsible caregiver?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

## CONTINUED STAY CRITERIA

*All fields are required to be completed on this form. Failure to do so may result in delay and/or denial.*

1. Please attach a current medication (both prescribed and illicit) reconciliation list. Please identify the current methadone dose. If the daily dose of methadone is >30 mg, provide clinical explanation for the dosage.

2a. Has the patient previously attempted to titrate down their dose of methadone? If yes, when and to what dosage?

2b. Do you and the patient plan to taper the dose in the next 3, 6, or 12 months? If no, please explain why.

2c. Do you anticipate being able to discontinue methadone treatment for this patient in the next 12 months? If yes, please provide details of the plan of discontinuation.

2d. What was the patient's daily dose of methadone at the initiation of treatment? \_\_\_\_\_

What was the patient's daily dose of methadone at twelve months of treatment? \_\_\_\_\_

3. Please list all other chronic medical conditions. If the patient has a severe and persistent mental illness, provide their medical history supporting and confirming the DSM-V diagnosis.

4. If the patient has achieved a measure of stability in behavioral or emotional functioning which may be jeopardized by discontinuation of opioid maintenance treatment, please provide evidence of measureable changes and improvements in the form of a detailed individualized Service Plan (ISP). Refer to the MaineCare Benefits Manual for ISP guidance. *The ISP must be attached to this form.*

5. Does the patient accept responsibility for his/her drug problem, and have they determined that ongoing treatment with Opiate Medication-Assisted Treatment (MAT) is the most effective means of preventing relapse? If yes, please provide evidence of improvement in all functional areas in the ISP.

**PLEASE NOTE!** All providers must provide a detailed ISP. Please provide urine drug screens for the past 12 months.

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*