# PRIOR AUTHORIZATION

State Fann 55941 (R4 / 5-17)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Recovery Works
INDIANA'S FORENSIC TREATMENT PROGRAM

*Please e-mail completed form to Recovery. Works@fssa.IN.gov.*

| Name of designated agency | Date *(month, day, year)* |
|---|---|
| Agency Name | Date service began |

Name of designated provider
Name of clinician/provider completing form

DARMHA identification number
REQUIRED

This is the correct box

Internal agency identification number
OPTIONAL, for your use

Type of prior authorization

☐ Prior Authorization Service ☐ Other

Prior Authorization Services:

☐ Medication Assisted Treatment (OTP Bundle) Monthly PA
☐ Clinically Managed High-Intensity Residential Services
☐ Medically Monitored Inpatient Detoxification
☐ Clinically Managed Low-Intensity Residential Services
☐ Thirty (30) to Ninety (90) Days Pre-Release Services

Make sure you check the correct box for the service you are requesting; rate & unit info on 2nd page

*Please provide a narrative about this participant. Ensure ALL questions are addressed.*

1. What specific circumstances make the requested service the most appropriate option for this participant? *(Answer should be individualized.)*
This should tell us about the individual person you're requesting service for and what about their situation makes this the best option for them. Must be individualized, no two should read the same. We want to know more than just that the person has a significant history of substance use - what is it about their individual needs, strengths, and circumstances that make this service appropriate.

2. What services and supports has the participant already utilized? Included what did and did not work well and why. *(If participant has had previous attempts with the service currently being requested, explain what will be different this time.)*
Should include all service history, not just at your agency. Should also include information about what worked/what didn't and why. Even if they weren't able to maintain recovery, there may be aspects of prior treatment they felt worked and we want to repeat, and aspects they didn't that we don't want to repeat - this should inform your approach moving forward. If participant has previously tried the service you're requesting, you must include information about why it is appropriate to try again and what will be different.

3. How does this service fit into the participant's overall individualized treatment plan and goals?
Be specific. Before recommending a service you should have a good idea of how it fits into larger treatment planning and we would like to know about those details. Answer should be individualized, like their treatment - each person's needs, circumstances, and strengths are different and treatment approaches should be tailored to them.

4. What other less intensive/ restrictive services were considered? Why do you believe those services are not appropriate at this time?
Before making a recommendation for service we expect that you have considered all potential options and ruled out other options for specific reasons. Tell us what was considered and why it was ruled out. Should be individualized and reflect understanding of person's individual needs, strengths, and circumstances.

5. Does the participant have insurance coverage? If not, what plan is in place to get them coverage?
If participant does not have insurance, explain what the plan is to get them connected to benefits. It is required that participants who do not have coverage will apply for and obtain insurance. If barriers exist, explain what they are and what plan you have to address them. Do not just write that participant doesn't have insurance without additional information.

* Units must be full values as noted in the Recovery Works Policies and Procedures Manual *(see reverse side).*

| Service duration /frequency | Rate/ units | Total |
|---|---|---|
| how long/often will service occur? | See rate sheet on back or on website | total dollar amount requested |

Detox should be no more than 7 days. Residential services are generally 21-28 days.

Rate per unit. Ex. Low Intensity Residential = $286

# Days * Rate = Total Dollar Amount

## REFERENCE: PRIOR AUTHORIZATION SERVICES AND REIMBURSEMENT

| SERVICE | RATE | UNIT | MAX | MRO MATCH ELIGIBLE |
|---|---|---|---|---|
| Medication Assisted Treatment - Buprenorphine Sublingual (Subutex) | $22.10 | 1 Day | $250.00 | NO |
| Medication Assisted Treatment- Buprenorphine / Nalone Sublingual (Suboxone) | $28.60 | 1 Day | $250.00 | NO |
| Medication Assisted Treatment - Methadone | $15.60 | 1 Day | $250.00 | NO |
| Medication Assisted Treatment - Naltrexone | $16.90 | 1 Day | $250.00 | NO |
| Medically Monitored Inpatient Detoxification | $286.00 | 1 Day | ---------- | NO |
| Clinically Managed High-Intensity Residential Services | $221.00 | 1 Day | ---------- | NO |
| Clinically Managed Low-Intensity Residential Services | $286.00 | 1 Dollar | ---------- | NO |

| *FOR OFFICE USE ONLY* | | |
|---|---|---|
| ☐ Approved ☐ Rejected | Date received *(month, day, year)* | Reference number |
| Approved by: | | |
| Amount or services approved | | |
| Additional information | | |
| Determination date *(month, day, year)* | | |