SummaCare

PRIOR AUTH REQUEST FORM FOR SUBSTANCE ABUSE TREATMENT

Please complete and fax this CONFIDENTIAL form. Incomplete or illegible documentation will result in a delay of the review process.
Please also attach to the following documents: CIWA or COWS scoring sheets (more than one set),
psychiatric assessment (if applicable), current prescribed medications (if applicable).

Please fax to 234-542-0811 for in-patient requests. Please fax to 234-542-0815 for out-patient requests.
For urgent requests only, please call 330-996-8710

HAS THE SERVICE BEING REQUESTED ALREADY BEEN PERFORMED?　　YES　　NO

This is for:　　Mental Health Treatment　　Substance Abuse Treatment

　　Inpatient Detox　　Inpatient Rehab　　Inpatient Residential
　　Partial Hospitalization　　Intensive Outpatient Program

PATIENT INFORMATION			
Last name:	First name:	DOB:	Member ID:

FACILITY INFORMATION	
Name of facility:	Address:
Phone:	How is facility licensed?　　　　　　NPI #: Tax ID #:　　　　Attending physician:
Contact person:	Contact phone #:　　　　Fax #:

PATIENT'S CURRENT STATUS (ALL DIAGNOSES)

Substance abuse diagnoses:

Psychiatric diagnoses:

Medical diagnoses:

Was the patient referred to the facility by the emergency room?　　☐ Yes　　☐ No

USE PATTERN

Drugs Used	Frequency	Amount	Date Last Used
☐ Opiates			
☐ Benzodiazepines			
☐ Stimulants			
☐ Inhalants			
☐ Alcohol			
☐ Crack/Cocaine			
☐ Marijuana			
☐ Other			

Admitting vital signs:　　Admitting drug screen results:　　Admitting breathalyzer results:

TREATMENT HISTORY

	Dates of Service	How Many Admits
☐ Detox		
☐ Rehab		
☐ Residential		
☐ PHP		
☐ IOP		

Were you released from treatment in the past 30 days?　　☐ Yes　　☐ No

WITHDRAWAL SYMPTOMS	
Dehydrated? ☐ Yes ☐ No Requires IV fluids? ☐ Yes ☐ No BUN: _____ Creatinine: _____	
Currently having protracted vomiting? ☐ Yes ☐ No If yes, what is the frequency? _____ The amount?	
Currently having muscle aches or abdominal cramping? ☐ Yes ☐ No	
Have you required PRN medications? ☐ Yes ☐ No If yes, what was given? _____	
Currently having severe agitation or tremors? ☐ Yes ☐ No	Currently having profuse sweating? ☐ Yes ☐ No If yes, were the clothes or sheets saturated? ☐ Yes ☐ No
History of withdrawal seizures? ☐ Yes ☐ No	History of delirium tremens? ☐ Yes ☐ No

CURRENT MENTAL STATUS (CHECK ALL THAT APPLY)	
☐ Confusion ☐ Disorientation ☐ Hallucinations What kind of hallucinations?	☐ Delirium ☐ Increasing lethargy ☐ Unable to stay awake ☐ Mini mental status score and attach _____

WITHDRAWAL SYNDROME REQUIRING MEDICATION ASSISTED WITHDRAWAL
Does the patient have habitual abuse of multiple substances? ☐ Yes ☐ No
Is the patient unable to comply with medication assisted withdrawal management in an outpatient detox due to cognitive impairment? ☐ Yes ☐ No   If yes, explain why:
Is support available? ☐ Yes ☐ No   If yes, explain support available:
Is the patient unable to tolerate or manage the severity of symptoms in a less intensive level of care? ☐ Yes ☐ No   If yes, explain why: