Blair County Medicated Assisted Treatment Program-Buprenorphine

The Goals of the Suboxone Services are as follows:

- Educate drug and alcohol treatment specialists, criminal justice and other professions regarding the benefits of medication assisted treatment and the recovery oriented system of care;
- As appropriate and applicable, involve the individual's family/support members in the treatment process; and
- Link individuals with community agencies/organizations that provide services, such as employment, housing, medical care, mental health service, etc.

Referral Procedure for Services and Target Population:
At any time during the continuum of case management and treatment, an individual can be identified as being a potential candidate. Persons who are appropriate for the service are to be referred to a network provider. The person must be engaged in pre-treatment or treatment to be eligible for the service. Determination of medical criteria and eligibility is based on an assessment by the provider medical staff.

Target population:
The following population may be eligible for this service:

18 years and older
Male or Female
Opiate Use Disorder
Blair County Resident and Blair County Liability Met

Physician physical examinations are part of the evaluation of candidates for this program.

Referral Procedure:
The case manager/treatment professional may contact the SCA or designee to discuss the funding of this intervention. Release of information must be provided in order for the SCA to discuss the individual's case.

The medical assistance application is required to be completed and submitted to the CAO office at time of the identification of the need.

The SCA/designee will review the funding levels for this service, identify funding for the service and, if available, provide authorization for the service.

The provider of the service will submit the buprenorphine referral form **(attachment A)** and Admission/Re-authorization form **(attachment B).**

Waiting List:
If at the time of contact with the SCA the funding is not available, the individual will be placed on a waiting list.

Blair Drug and Alcohol Partnership (BDAP) will be the point of contact to determine funding and authorization for this service. The review process for the case by BDAP staff will include receipt of all required paperwork and confirmation from the provider (with confidentiality release) of the individual's current participation in treatment. If this is a physical health provider office-based referral and the patient is not engaged in treatment, an appointment to complete an assessment will be made with the patient. Once a case is reviewed, BDAP will provide authorization for the service within funding guidelines. Individuals participating in the program are required to be engaged in the assessed level of care. Individuals will be assessed for non-treatment needs and recovery supports, and offered resource, intensive case management services and/or certified recovery specialist services when meeting the criteria for those services.

Payment of services
The SCA has identified the following funding resources for this service:
Department of Drug and Alcohol Program State and Federal Alcohol and Drug Block grant, and other state and federal grants;
Department of Public Welfare: Behavioral Health Special Initiative and ACT 152;
Pennsylvania Commission on Crime and Delinquency Funds; and
Other funds as identified.

Buprenorphine Referral Form

Individual's Name _____

Last four of SS# _____ **DOB** _____

Provider: _____

Provider Contact Person: _____

Phone # _____

Fax # _____

Preliminary Diagnosis: _____

Insurance Information:

_____The individual does not have insurance; liability form must be attached if completed by provider

This certifies that the above identified individual is currently participating in treatment and the treatment plan indicates the need for these services, or is participating in pre-treatment activities and has been assessed as needing this service. In addition the person has met the public funded liability criteria.

Signature of person referring _____ Date _____

I have been educated on Buprenorphine and risks associated with the medication to include high risk behaviors that can result in overdose. I have been made aware that the payment for Buprenorphine medicated assisted treatment is limited. I further understand to be eligible for this assistance, I agree to follow the recommendations for drug and alcohol treatment, self-help groups, or other recovery supports as recommended. I understand my funding will be discontinued if I am non-compliant with my treatment recommendations.

Signature of the Individual _____ Date _____

FAX Form to: Blair Drug and Alcohol Partnerships: 814-381-0922

Attachment B – 7-1-2020

Blair County Drug and Alcohol Buprenorphine Admission/Re-Authorization Form

Individual's Name_____

Last Four of SS#_____**DOB:**_____

Provider Name: _____

Buprenorphine Service Request

Date of Admission:_____

All Buprenorphine services will be authorized 3 months at a time. Confirmation the patient is still engaged in treatment and/or recovery supports is required for ongoing authorization of services.

Buprenorphine Induction: Initial History and Physical to establish the individual with the facility's doctor
Episode of Service: Can bill one time at time of admission to the service

_____Episode: Maximum 1 time per admission

Buprenorphine Doctor Visit: Medication Management-Authorized base on program model and phase of treatment
Episode of Service: Authorized up to 3 months of care per authorization –Maximum 13 visits in first 3 months, then based on the model of the program and phase of treatment.

_____ Episode: Maximum 13 visits per authorization

Buprenorphine Nurse Visit: Medication Management –Authorized based on program model and phase of treatment
Episode of Service: Authorized up to 3 months of care per authorization-Maximum 13 visits in first 3 months, then based on the program and phase of treatment.

_____ Episode: Maximum 13 visits per authorization

MA Eligibility Status: In order for an authorization to be generated the Medical Assistance application is required to be completed and submitted to the CAO office. Please indicate that this process has been satisfied by checking the status below:

_____Date MA Application was faxed to CAO office.

Name, Date and Phone Number of Person completing the form: (Please Print)

_____

NAME **DATE** **Phone#**

Fax to Blair County Drug and Alcohol: 814-381-0922 Any questions please contact Blair Drug and Alcohol at 814-381-0921

_____

Blair Drug and Alcohol Partnerships Use Only:

Cost of Medication: CM must determine if medication costs are needed for the client, if so process the request through the fiscal department.

_____Medication costs are NOT needed (CM to Initial)

_____Name of Pharmacy: _____Date Contacted the Pharmacy (release on file)

_____Name of Pharmacy Representative contacted

_____Phone Number _____Projected Cost

_____ _____

CM Name (please print) **DATE**

Funding Target Populations: _____IDU Pregnant Women ____Pregnant SUD _____Overdose ____IDU ____Veteran

Other Funding: Specialty Court: _____DUI _____Drug