



Substance Use Disorder Prior Authorization Request Form

Complete and fax all requested information below including any supporting documentation as applicable to Highmark Health Options at **1-855-412-7997**. **Authorization is based on medical necessity. Incomplete information or illegible forms will delay processing.**

Questions or concerns? Call Utilization Management at 1-844-325-6251, Monday through Friday, 8 a.m. to 5 p.m.

Date: _____

Member Information		
Member Name	Member ID	Date of Birth
Requested ASAM Level of Care		

Provider Information	
Facility Name	NPI Number
Facility Address	
Provider Name	Provider NPI Number
Provider Phone	Provider Fax
Contact Person Completing Form	Contact Phone
Contact Person at Facility	Contact Fax
Date of Admission or Start of Care Under Current Plan	
Admitting Physician	
Diagnosis	ICD 10 Code

Type of Request	
<input type="checkbox"/> Admission	<input type="checkbox"/> Continued Stay
Is the member under the influence of drugs or alcohol at the time of admission? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Describe presenting problem.

Clinical Information

Provide clinical information. Include current withdrawal symptoms, vital signs, COWS/CIWA, etc.

Drug Screen Results
Provide drug screen results.
Is this a readmission? <input type="checkbox"/> Yes <input type="checkbox"/> No
List all diagnoses.

Current Medications		
Medication	Dosage	Frequency

Substance Use History
Describe substance use history. Include amount, duration, frequency, last use, etc.

Substance Use Treatment History
Describe prior substance use treatment history. Include facility, dates, clean time, etc.

ASAM Criteria		
Level of Care	Risk Level	Criteria Indicated
Dimension I:		
Dimension II:		
Dimension III:		
Dimension IV:		
Dimension V:		
Dimension VI:		



Treatment Plan

Describe treatment plan and orders with admission and provide number of days requested.

Potential Barriers to Discharge and/or Stressors

List potential barriers to discharge and/or stressors.

Support System

Does the member have family/informal supports (e.g., friends, significant other, partner, spouse, family, or other natural or professional supports) upon discharge who are able to help the member maintain behavioral wellness?

Yes No Unknown

Provide a list of family/informal supports. Include contact information, address, and phone of member discharge location. Share any other information that will help member outreach.