HIGHMARK. HEALTH OPTIONS

Substance Abuse
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 Çare Under Current Plan	
Admitting Physician	
Diagnosis	**ICD 10 Code**

Type of Request	
☐ **Admission**	☐ **Continued Stay**
Is the member under the influence of drugs or alcohol at the time of admission? ☐ Yes ☐ No	

Describe presenting problem.

Clinical Information

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

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Drug Screen Results
Provide drug screen results.
Is this a readmission? ☐ Yes ☐ 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.

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

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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.