DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
CENTER FOR SUBSTANCE ABUSE TREATMENT

Form Approved: OMB Number 0930-0206
Expiration Date: 01/31/2010
See OMB Statement on Reverse

Reset

Exception Request and Record of Justification Under 42 CFR § 8.11(h)

DATE OF SUBMISSION:

Note: This form was created to assist in the interagency review of patient exceptions in opioid treatment programs (OTPs) under 42 CFR § 8.11(h).

Detailed INSTRUCTIONS are on the cover page of this form. PLEASE complete **ALL** applicable items on this form. Your cooperation will result in a speedy reply. Thank you.

BACKGROUND INFORMATION

Program OTP No: (e.g., AL-10001-M) ☐☐ - ☐☐☐☐☐ - ☐ **Patient ID No:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Program Name: _____

Telephone: _____ **Fax:** _____ **E-mail:** _____

Name & Title of Requestor: _____

Patient's Admission Date: _____ **Patient's current dosage level:** ___ mg ___ Methadone ___ LAAM ___ Buprenorphine ___ Other: _____

Patient's program attendance schedule per week (Place an "X" next to all days that the patient attends*): ___ **S** ___ **M** ___ **T** ___ **W** ___ **T** ___ **F** ___ **S**

*If **current** attendance is less than once per week, please enter the schedule: _____

Patient status: ___ Employed ___ Homemaker ___ Student ___ Disabled ___ Other:

REQUEST FOR CHANGE

Nature of Request:

___ Temporary take-home medication ___ Temporary change in protocol ___ Detoxification exception ___ Other: _____

Decrease regular attendance to (Place an "X" next to appropriate days*): ___ **S** ___ **M** ___ **T** ___ **W** ___ **T** ___ **F** ___ **S** **Beginning date**: _____

*If **new** attendance is less than once per week, please enter the schedule: _____

Dates of Exception: **From** _____ **to** _____ **# of doses needed:** _____

Justification:

___ Family Emergency ___ Incarceration ___ Funeral ___ Vacation ___ Transportation Hardship

___ Step/Level Change ___ Employment ___ Medical ___ Long-Term Care Facility ___ Other Residential Treatment

___ Homebound ___ Split Dose

___ Other:

REQUIREMENTS

Regulation Requirements:

1. **For take-home medication:** Has the patient been informed of the dangers of children ingesting methadone or LAAM? ___ Yes ___ No ___ N/A
2. **For take-home medication:** Has the program physician determined that the patient meets the 8-point evaluation criteria to determine whether the patient is responsible enough to handle methadone as outlined in 42 CFR § 8.12(i)(2)(i)-(viii)? ___ Yes ___ No ___ N/A
3. **For multiple detoxification admissions:** Did the physician justify more than 2 detoxification episodes per year and assess the patient for other forms of treatment (include dates of detoxification episodes) as required by 42 CFR § 8.12(e)(4)? ___ Yes ___ No ___ N/A

Submitted by: _____ (Printed Name of Physician) _____ (Signature of Physician) _____ (Date)

APPROVAL

State response to request: ___ Approved ___ Denied _____ (State Methadone Authority) _____ (Date)

Explanation:

Federal response to request: ___ Approved ___ Denied _____ (Public Health Advisor, Center for Substance Abuse Treatment) _____ (Date)

Explanation:

Please fax to CSAT/DPT at (240) 276-1630 or e-mail: otp@samhsa.hhs.gov

This exception is contingent upon approval by your State Methadone Authority (as applicable) and may not be implemented until you receive such approval.

Purpose of Form: This form was created to facilitate the submission and review of patient exceptions under 42 CFR § 8.11(h). This does not preclude other forms of notification.

Paperwork Reduction Act Statement

Public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0206); Suite 7-1043, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0206.