DVHA CLINICAL UNIT

DEPARTMENT OF VERMONT HEALTH ACCESS
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The 2010 Vermont legislative session passed Act 156 for FY 2011 which now limits treatment providers to eight urine drug tests per month. There may be some circumstances in which there may be a clinical rational for additional testing. The "Urine Drug Test Prior Authorization Form" will be utilized by those providers who believe additional testing is warranted. All requests for prior authorization must be approved by the DVHA Medical Director.

URINE DRUG TEST PRIOR AUTHORIZATION FORM

Date of Request: _____________

Patient Name: ____ Gender: ☐ Male ☐ Female

Medicaid ID: ___________________________ Date of Birth: ___________________________

Initial Therapy Date: ______________________

Specific Illicit Drugs used by Patient:____

Specific Drugs Being Tested: ____

Number of Additional Urine Drug Tests Requested over Eight: _______________________________________

Number of Months requested: ____

History of Buprenorphine Treatment: ☐ New ☐ Existing ☐ Relapse.

History of other substance abuse Treatment: ☐ New ☐ Existing ☐ Relapse

Compliance: ____

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Clinical Rationale for Additional Urine Drug Tests: ____

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Requesting Provider Name: ____________________________________

Vermont Medicaid Provider Number: _________________

Provider Address: ____

Office Contact Person: ___________________________ Telephone Number: _____________ Fax: _________

Test performed by: ☐ Physician's Office ☐ Independent Lab ☐ Hospital Outpatient Lab

Name of Lab (if applicable): ____

Vermont Medicaid Provider Number for Lab: _________________

____________________________________ ___________________________

Provider Signature Date

____________________________________ ___________________________

DVHA Medical Director Signature Date

Effective/Created: 7/1/10