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: 06/30/2016
See OMB Statement on Reverse

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 ___ 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? ___ Yes ___ No ___ N/A
2. **For take-home medication:** Has the program physician considered the 8-point evaluation criteria to determine whether the patient is suitable for dispensed methadone or buprenorphine 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

Comments: _____

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

APPROVAL

State response to request: ___ Approved ___ Denied ___ Decision not required _____ (State Methadone Authority) _____ (Date)

Explanation: _____

Federal response to request: ___ Approved ___ Denied ___ Decision not required _____ (Public Health Advisor, Center for Substance Abuse Treatment) _____ (Date)

Explanation: _____

The preferred method for submitting this form to CSAT/DPT is online at the SAMHSA OTP Extranet Web site, http://otp-extranet.samhsa.gov. For instructions or technical support, contact the OTP Extranet Information Center at 1-866-OTP-CSAT (1-866-687-2728) or otp-extranet@opioid.samhsa.gov. If you are unable to submit online, the form may be faxed to (240) 276-1630 or e-mailed as an attachment to otp@samhsa.hhs.gov.

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

FORM SMA-168 (revised 2010) (FRONT)

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