

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:
 (Same as FDA ID)

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Patient ID No:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Program Name:

Telephone:

Fax:

E-mail:

Name & Title of Requestor:

Patient's Admission Date:

Patient's current dosage level:

Methadone
 Other:

LAAM

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
 ___ Other: _____

___ Unemployed

___ Homemaker

___ Student

___ Disabled

REQUIREMENTS FOR CHANGE

Nature of

___ 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

*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: _____

Regulation Requirements:

- For take-home medication:** Has the patient been informed of the dangers of children ingesting methadone or LAAM? ___ Yes ___ No ___ N/A
- 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
- 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:

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Printed Name of Physician

Signature of Physician

Date

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/OPAT, (301) 443-3994 or Email: otp@samhsa.gov

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

FORM SMA-168 (FRONT)

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); Room 16-105, Parklawn Building; 5600 Fishers Lane, 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.

FORM SMA-168 (BACK)

