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

BACKGROUND INFORMATION

CHANGE

FOR

REQUIRED CENTERS

State response to request:

Form Approved: OMB Number 0930-0206 Expiration Date: 09/30/2006 See OMB Statement on Reverse

DATE OF SUBMISSION **Exception Request and Record of Justification** Under 42 CFR § 8.11 (h) This form was created to assist in the interagency review of patient exceptions in opioid treatment progrms (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. Program OTP No: Patient ID (Same as FDA No: ID) Program Name: Fax: Telephon E-mail: Name & Title of **Requestor:** Patient's Methadone LAAM current Patient's Admission dosage level: mg Patient's program attendance schedule per (Place an "X" next to all days that the patient _ S ___ M __ T __ W __ T __ F __ S attends*): *If current attendance is less than once per week, please enter the schedule: Patient status: Employed Unemployed Homemaker Student Disabled Nature of Temporary take-home Temporary change in Detoxification Other medication protocol exception Decrease regular attendance to **Beginnin** (Place an "X" next to appropriate _ S ___ M ___ T ___ W ___ T ___ F ___ S days*): *If **new** attendance is less than once per week, please enter the schedule: Dates of # of doses **Exception:** needed: Justificatio Family Emergency Incarceration Vacation Transportation Hardship Long Term Care Other Residential Step/Level Change Medical Employment Facility Treatment Homebound Split Dose Other: 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)-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)? Submitted by: Printed Name of Physician Signature of Physician Date

		Approved	Denied			
	_	_		State Methadone Authority	Date	
Explanation	:					
Federal resp	onse 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)

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)

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