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: 09/30/2006
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 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.

BACKGROUND INFORMATION

Program OTP No: (Same as FDA ID) ___ ___ – ___ ___, ___ ___ ___ – ___

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 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 Unemployed Homemaker Student Disabled Other:

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**

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:

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**

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.

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