

**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.

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: _____

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: _____

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: _____
(e.g., information from State PDMP, drug screen results, if applicable.)

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

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.

BACKGROUND INFORMATION

REQUEST FOR CHANGE

REQUIREMENTS

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); Suite 7-1043, 1 Choke Cherry Road, 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 (revised 2010) (BACK)