BACKGROUND INFORMATION REQUIRED FOR ALL EXCEPTIONS

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

Form Approved: OMB Number XXXX-XXXX
Expiration Date: xx/xx/xxxx
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 provided at http://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs/submit-exception-request. PLEASE complete **ALL** applicable items on this form and submit online* for a prompt reply. Thank you.

Program OTP No: (e.g., AL-10001-M) | | | – | | | | | | – | | **Patient ID No:** | | | | | | | | | | | | | |

Program Name: _____

Telephone: _____ **E-mail:** _____

Name & Title of Requestor: _____

Patient's Admission Date:_____

Patient's applicable drug(s) and dosage (check all that apply):

___ Methadone ___ mg
___ Buprenorphine ___ mg
___ Other ___mg

Most recent urinalysis result (check all that apply):

___ Methadone ☐ positive ☐ negative
___ Buprenorphine ☐ positive ☐ negative
___Other ☐ positive ☐ negative

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 __ Weather Crisis
__ 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: _____

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

APPROVAL

State response to request: __Approved __Denied _____ _____
State Opioid Treatment Authority — Date

__Decision not required

Explanation: _____

Federal response to request: __ Approved __ Denied _____ _____
Public Health Advisor, Center for Substance Abuse Treatment — Date

__ Decision not required

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.

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