PRACTIONER REPORTING FORM	FORM NUMBER

PLEASE DON'T FORGET TO SIGN AND DATE THIS FORM

1. NAME OF PRACTITIONER:

2. State Medical License Number:

3. Specialty:

4. NPI and License Number:

5. ADDRESS OF PRIMARY SERVICE LOCATION *(Include Zip Code)*	6. TELEPHONE NUMBER *(Include Area Code)*
	7. FAX NUMBER *(Include Area Code)*
	8. EMAIL ADDRESS *(Required)*

9: This report covers the 12-month period beginning _____(month), _____ (year) and ending _____(month), _____ (year).

10a. How many patients were prescribed or dispensed covered medications during each month of the preceding 12 months:

Month	#	Month	#	Month	#	Month	#	Month	#	Month	#

10b. Indicate the number of patients who were prescribed or dispensed covered medications during each month of the preceding 12 months **and also** received behavioral health services, as defined in section 42 C.F.R. § 8.2, from the prescribing practitioner:

Month	#	Month	#	Month	#	Month	#	Month	#	Month	#

10c. Indicate the number of patients who were prescribed or dispensed covered medications during each month of the preceding 12 months **and also** were referred for behavioral health services to another entity through an established formal agreement:

Month	#	Month	#	Month	#	Month	#	Month	#	Month	#

11. Check each of the elements included in the practitioner's diversion control plan	Y/N
a. Random clinical drug testing:	
b. Routine clinical drug testing:	
c. Random patient recall visits for covered medication counts:	
d. Provision of information to patients about proper medication storage, including not sharing medication:	
e. Prescription drug monitoring program (PDMP) or other central repository of prescribing and dispensing record queries:	

If you checked 11e. please complete item 12.

12. Under your diversion control plan, under which circumstances do you check the PDMP or other central repository? Check all that apply:

At every patient visit:		On first visit:		According to a schedule such as quarterly:		Based on clinical assessment of risk:	
Other:							

13. Any other elements of the diversion control plan not already described (e.g., implants, misuse deterrent packaging such as timed single dose dispensing packaging, and disposal):

14. I certify that the information presented above is true and correct to the best of my knowledge. Note: Any false, fictitious, or fraudulent statements or information presented above or misrepresentations relative thereto may violate Federal laws and could subject you to prosecution, and/or monetary penalties, and or denial, revocation, or suspension of DEA registration, and/or suspension or revocation of SAMHSA's approval of the Request for Patient Limit Increase. (See 18 USC § 1001; 31 USC §§ 3801–3812; 21 USC § 824; 42 C.F.R. § 8.650.)

x_____ _____

Signature of Practitioner Date

Substance Abuse and Mental Health Services Administration	This form is intended to ensure compliance with 42 C.F.R. Part 8, Subpart F.

Privacy Act Information

Authority: Section 303 of the Controlled Substances Act of 1970 (21 USC § 823(g)(2)). Purpose: To obtain information required to determine whether a practitioner meets the requirements of 21 USC § 823(g)(2) and 42 C.F.R. Part 8, Subpart F. Routine Uses: Disclosures of information from this system are made to the following categories of users for the purposes stated:

- Medical specialty societies to verify practitioner qualifications.
- Other federal law enforcement and regulatory agencies for law enforcement and regulatory purposes.
- State and local law enforcement and regulatory agencies for law enforcement and regulatory purposes.
- Persons registered under the Controlled Substance Act (PL 91-513) for the purpose of verifying the registration of customers and practitioners.

Effect: This form was created to facilitate the review of waivers under 21 USC § 823(g)(2) and approvals of Request for Patient Limit Increase under 42 C.F.R. Part 8, Subpart F. This does not preclude other forms of notification.

Paperwork Reduction Act Statement

Public reporting burden for completing this form is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the completed form. 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 XXXX-XXXX. 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 (XXXX- XXXX); Room X-XXXX, 5600 Fishers Lane, Rockville, MD 20857.

INSTRUCTIONS

This information should be entered electronically at http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management. If you are unable to enter this electronically, please print this form and make sure your responses are typed or printed legibly. The paper form can be mailed to:

Substance Abuse and Mental Health Services Administration
Attn: Center for Substance Abuse Treatment DPT/Practitioner Reports
5600 Fishers Lane, 13E36
Rockville, MD 20852

For items 1-8, please enter the information as requested.

For item 9, please enter the 2-digit month and 4-digit year for the both the beginning and ending months of the 12 month period on which you are reporting.

For item 10a, please enter the 2-digit month and number of patients to whom you prescribed or dispensed covered medications[i] for each of the 12 months on which you are reporting.

Please note that if the provider is operating at or near capacity and experiences patient turnover during a month, it is possible that he/she will report more than the total allowable caseload, even if the provider never had a concurrent caseload exceeding the total for which he/she is waivered. Therefore, SAMHSA will not regard these reported totals as violations unless they are consistently over the limit by, for example, 10 or more patients.

For item 10b, please enter the 2-digit month and number of patients to whom you both prescribed or dispensed covered medications and directly provided behavioral health services for each of the 12 months on which you are reporting.*

For item 10c, please enter the 2-digit month and number of patients to whom you prescribed or dispensed covered medications but who received behavioral health services[ii] from another entity through a formal established agreement for each of the 12 months on which you are reporting.* When using an electronic health record to describe the clinical reason why a provider is sending the patient to another provider for care, please use the terms “psychosocial or case management services.”

For item 11, please check the box next to each element included in your diversion control plan. You should check all the boxes that apply.

For item 12, please check the boxes that reflect the circumstances under which these queries are made.

For item 13, please enter any elements in your diversion control plan that were not included in the list. For more information about diversion control plans, please refer to http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf and http://store.samhsa.gov/shin/content/SMA16-4938/SMA16-4938.pdf.

For item 14, please review the form for accuracy and completion. Sign and date the form.

[i] Covered means drugs or combinations of drugs that are covered under 21 U.S.C. 823(g)(2)(c), such as buprenorphine.

[ii] Behavioral health services is defined as any non-pharmacological intervention carried out in a therapeutic context at an individual, family, or group level. Interventions may include structured, professionally administered interventions (e.g., cognitive behavior therapy or insight oriented psychotherapy) delivered in person, interventions delivered remotely via telemedicine shown in clinical trials to facilitate medication-assisted treatment outcomes, or non-professional interventions.