SAMHSA

275 Waivered Practitioner Annual Reporting Form

SMA-167 Form Approved: [illegible]

Date. **TBD**

See OMB Statement Below

See instructions below

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1 . NAME OF PRACTITIONER

First Name	Middle Name	Last Name	Suffix
Steven	A.	Pelig	D.O.

2. State Medical License Number	License State	3. Specialty	4. NPI and License Number
DO32-	Rhode Island		AP2 248

5. ADDRESS OF PRIMARY LOCATION

270 Hamilton-Allenton Road

Address Line 2

test

City

North Kingstown

State

Rhode Island

Zip Code

02852

6. TELEPHONE NUMBER

401-295-0012

Extension (if applicable)

7. FAX NUMBER

xxx-xxx-xxxx

8. EMAIL ADDRESS

rmuksian@bryant.edu

Confirm Email Address

Dropdown Box Dropdown Box

9: This report covers the 12-month period beginning ______(VAR_month), ______(VAR_year)

Filemaker will store this report using the month as year as part of the name

The months throughout question 10 will populate based upon the user input from question 9.

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

Month	#Patients
VAR_month	
VAR_month +1	
VAR_month +2	
VAR_month +3	
VAR_month +4	
VAR_month +5	
VAR_month +6	
VAR_month +7	
VAR_month +8	
VAR_month +9	
VAR_month +10	
VAR_month +11	

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	#Patients
VAR_month	
VAR_month +1	
VAR_month +2	
VAR_month +3	
VAR_month +4	
VAR_month +5	
VAR_month +6	
VAR_month +7	
VAR_month +8	
VAR_month +9	
VAR_month +10	
VAR_month +11	

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	#Patients
VAR_month	
VAR_month +1	
VAR_month +2	
VAR_month +3	
VAR_month +4	
VAR_month +5	
VAR_month +6	
VAR_month +7	
VAR_month +8	
VAR_month +9	
VAR_month +10	
VAR_month +11	

11. Check each of the elements included in the practitioner's diversion control plan

- ☐ Random clinical drug testing:
- ☐ Routine clinical drug testing:
- ☐ Random patient recall visits for covered medication counts:
- ☐ Provision of information to patients about proper medication storage, including not sharing medication:
- ☐ Prescription drug monitoring program (PDMP) or other central repository of prescribing and dispensing record queries:

(only appears if you checked PDMP question)

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

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.)

Please type your name to sign this electronic form.

Please re-enter your DEA Registration Number to verify:

Submit

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).Routine Uses: Disclosures of information from this system are made to the following categories of users for the purposes stated:

A. Medical specialty societies to verify practitioner qualifications.

B. Other federal law enforcement and regulatory agencies for law enforcement and regulatory purposes.

C. State and local law enforcement and regulatory agencies for law enforcement and regulatory purposes.

D. 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 submission and review of waivers under 21 USC § 823(g)(2). This does not preclude other forms of notification.

Paperwork Reduction Act Statement

Public reporting burden for completing this form is estimated to average 4 minutes 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 0930-0234. 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 (0930-0234); 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 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 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.