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

Exception Request and Record of Justification Under 42 CFR § 8.11(h)

Form Approved: OMB Number XXXX-XXXX
Expiration Date: xx/xx/xxxx
See OMB Statement on Reverse

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 1-866-348-5741 or OTP-Help@jbsinternational.com.

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

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); 5600 Fishers Lane, 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.