Magellan HEALTHCARE℠

Adult Substance Use Disorder Treatment
Re-Auth Request Form
Fax to Magellan: 1.888.656.4916

Requested Level of Care: ☐ **IOP** ☐ **CS/SA** ☐ **HWH** ☐ **IR** ☐ **STR** ☐ **DDR** ☐ **TC**

Client Name as listed on Authorization: _____ **Client Date of Birth:** _____

Eligibility: Non-Medicaid Eligible: ☐ Yes SSN: _____ If Yes, please indicate Case Number: _____

Medicaid Managed Care Eligible: ☐ Yes If Yes, please indicate Member's Medicaid Number: _____

Agency: _____ **Contact Person:** _____ **Phone Number:** _____

Name/credentials/phone number of clinical contact in case further review is needed: _____ **ASAM Level:** _____

Auth End Date: _____ **Anticipated Discharge Date:** _____ **Service Location:** _____

Current DSM 5 Diagnosis: _____

Describe progress, lack of progress and/or new problems for each ASAM dimension and how these are being addressed:

1.	**Acute Intoxication and/or Withdrawal**	
2.	**Biomedical Conditions and Complications**	
3.	**Emotional/Behavioral or Cognitive Conditions and Complications**	
4.	**Readiness to Change:** ***Current Stage:***	**Describe Motivational Enhancement Approach:**

5.	**Relapse, Continued Use or Continued Problem Potential**	
6.	**Recovery Environment Relapse Plan**	

Team Approved D/C Plan (Include Rationale) :

Clinical Rationale: _____

_____

_____

_____

Please list current medications: _____

Addiction Medications: (please check) ☐ **Naltrexone** ☐ **Vivitrol** ☐ **Campral** ☐ **Topamax**

☐ **Baclofen – for alcohol** ☐ **Suboxone** ☐ **Methadone – for opiods**

Will the client be discharged with medication to assist with addiction treatment? ☐ Yes ☐ No

If "yes", please list medication. If "no", please comment on efforts made in this area:

_____

_____