Narcotic Treatment Program Exception Request

This form was created to facilitate the submission of patient exceptions to state regulations CCR, Title 9, Chapter 4 in accordance with Section 10425. This form is intended for exceptions that only require state approval and do not require federal approval. This does not preclude other forms of notifications. DHCS may grant a temporary exception request in accordance with CCR, Title 9 Section 10425 for individual licensed NTP locations on a per patient basis.

The following should be submitted as an exception request via this form and NOT through the CSAT extranet:

- **Admission Criteria:** Specifically, the one-year history of opioid addiction is no longer required by federal law. In addition, SAMHSA removed the requirement that people under the age of 18 must have completed two unsuccessful episodes of treatment. The revised 42 CFR, Part 8 regulations removed this requirement as a way to expand access to care. Instead, the provider should assess the person and consider their problematic patterns of opioid use, determining their needs and eligibility for treatment based on their assessment and evaluation of the person. The one year and two unsuccessful detoxification attempts exception requests require state approval only.
- **Split-dosing:** A medical provider should assess the patient and determine the needs of the person based on their individualized assessment and evaluation. Split-dosing is allowable per federal law. Split-dosing exception requests require state approval only.
- **Changes to the Urinary Drug Screens (UDS) and counseling schedule:** At various times in treatment a patient may become non-compliant with the UDS and/or counseling schedule. This could be the result of incarceration, residential treatment, or non-compliance. Federal approvals are not required for changes to the aforementioned, and therefore should not be submitted via the CSAT extranet. Counseling and UDS exception requests require state approval only. Please note, in accordance with Section 10345(e) the medical director may adjust or waive at any time after admission, by medical order, the minimum number of minutes of counseling services in the patient's treatment plan as specified in Section 10305(h).
- **Discharge:** Discharge occurs based on state requirements and exception requests, such as delaying a discharge, are not required, and should not be submitted as an exception request via the CSAT extranet. Discharge exception requests required state approval only.
- **Take-Home Doses:** Changes in a patient's dosing schedule including, step-level increases or decreases, vacation bottles, and hardship due to transportation or employment no longer require federal approval and should not be submitted via the CSAT extranet. As noted earlier, the regulations have allowed providers to have greater autonomy and changes to take-home schedules should occur based on the practitioner's assessment of the individual patient's level of stability, level of risk and their ability to safely manage medication. Please note that treatment should be individualized. Please refer to the 42 CFR Part 8 regulations as the allowable number of take-home bottles based on time in treatment has changed to allow greater flexibility. Take-home exceptions to state law require state approval only.
- **Guest Dosing:** guest dosing does not require federal approval and requests should not be submitted via the CSAT extranet. Guest dosing exception requests require state approval only.
- **Federal Holidays:** Federal approval is not required and should not be submitted via the CSAT extranet. Holiday exception requests require state approval only.

Patient exception requests to 42 CFR, Part 8 will need to be submitted through the CSAT portal as these are federal laws and require SAMHSA approval. Below you will find links to the regulations and frequently asked questions, an outline for exception requests and instructions on completing the SMA-168 form.

- Regulations: eCFR :: 42 CFR Part 8 – Medications for the Treatment of Opioid Use Disorder
- FAQs: 42 CFR Part 8 Final Rule – Frequently Asked Questions | SAMHSA

Please complete **All** fields on this form. All fields are required and should not be left blank. Leaving a field blank can result in a denial and cause a delay in treatment. Incomplete fields will require the NTP analyst to contact you to obtain the missing information thus delaying the exception request process. Your Cooperation will result in a speedy reply. As a reminder, no identifying information for the patient or family members (i.e., designee) should ever be included in the exception request, this includes both names and DOB. Thank you.

Program Name: _____

Program NTP Number: _____ Patient ID Number: _____

Telephone Number: _____ Fax Number: _____

Email: _____

Requestor: _____ Title: _____

Patient's Admission Date (reminder this is the admission date to the NTP): _____

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: (Check all the days that the patient attends*)

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ N/A

*If N/A was marked or if current attendance is less than once per week, please explain or enter schedule:

Patient's Status (Check all that apply):

☐ Employed ☐ Homemaker ☐ Student ☐ Disabled ☐ Other: _____

Nature of Your Request:

☐ **If individual is incarcerated and the program is sending an exception for counseling and UDS** (only needs to be sent via the CSAT extranet if requesting less than 8 UDS per year drug testing minimum; 42 CFR 8.12(f)(6))

☐ **Split Dosing** (The medical director or program physician may, upon determination that split dose is medically necessary, order that a patient receive his or her daily dose of medication split in two doses; CCR Title 9 Section 10386(a)). Split dosing exception requests only require state approval and should not be submitted via the CSAT extranet.

☐ **Time in Treatment** (With prior Department approval, the program may make an exception to this requirement only if the program physician determines, based on his or her medical training and expertise, that withholding treatment constitutes a life- or health-endangering situation. The program physician shall document the reason for this determination in the patient record; CCR Title 9 Section 10270(d)(1)).

☐ **Discharge Exceptions** (SAMHSA does not specify discharge requirements, therefore discharge exception requires only state approval. Discharge exception requests to CCR Title 9 Section 10415 need to be submitted via this form and not via the CSAT extranet.)

☐ **Temporary take-home medication**

☐ **Temporary change in protocol**

☐ **Detoxification exception**

☐ **Other, please describe and include specific regulation:**

Decrease regular attendance to: (place an "X" next to the appropriate days*)

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Beginning date: _____

*If new attendance is less than once per week, please enter schedule:

Dates of Exception (the "From:" and "To:" fields reflect the date range of the exception request):

From: _____ **To:** _____

Number of doses needed (number of doses needed reflects the number of doses being provided at any given time. For example, if a patient is incarcerated and the date range is for 90-days but the program is delivering weekly doses to the carceral facility, then the number of doses should reflect 7. If delivery/pick-up is occurring every 2 weeks, then the number of doses should reflect 14.): _____

Justification (choose all that apply):

☐ **Funeral** ☐ **Vacation** ☐ **Employment** ☐ **Transportation Hardship**

☐ **Medical** ☐ **Split Dose** ☐ **Incarceration** ☐ **Long-Term Care Facility**

☐ **Homebound** ☐ **Weather Crisis** ☐ **Family Emergency** ☐ **Step/Level Change**

☐ **Other Residential Treatment**

☐ **Other** (This can be used to write a description of the nature of the request. Descriptions should be detailed and include specific language for chain of custody requests, chain of custody must be identified in the description as should the way in which medication is being provided, i.e., via pick-up or delivery and frequency of the pick-up or delivery.):

Regulation Requirements:

- **For take-home medications:** Has the patient been informed of the dangers of children ingesting methadone? ☐ Yes ☐ No ☐ N/A
- **For take-home medications:** Has the program physician considered the evaluation criteria to determine whether the patient is suitable for dispensed methadone or buprenorphine as outlined in 42 CFR Section 8.12(i)? ☐ Yes ☐ No ☐ N/A

Submitted By:

Printed Name of Physician | Signature of Physician | Date

Submit

State Response to Request:

☐ **Approved** ☐ **Denied** ☐ **Decision Not Required**

Explanation: