HIGHMARK WHOLECARE

Substance Use Disorder Authorization Request Form

Please Fax Completed Form To: 1-888-245-2027
Behavioral Health Department: 1-800-685-5209

Type of request: □ **Admission** □ **Continued Stay/Authorization #**_____

Member Name:	**Member ID Number:**
Member Phone Number:	**Member Date of Birth:**
***Requesting* Facility Name:**	**Person Completing Form/Phone Number:**
***Admitting* Facility:**	**Admitting Facility Contact/ Phone Number:**
Date/Time of Admission:	**Treating Physician:**
Tobacco Use: □ **No** □ **Yes**	**Legal Issues:** □ **No** □ **Yes** ***(please explain):***
Requested ASAM Level of Care:	**Drug screen results and alcohol level:**
Withdrawal Scale Scores (WAS/COWS):	**Number of Days Requested:**

Member's Preferred Language:

Vitals

BP:	**Pulse:**	**Resp:**	**Temp:**

List All Diagnoses *(Including Medical Comorbids)*

Presenting Problem *(include member's motivation for treatment)*

ASAM Criteria *(specify level of care and risk score)*

DIMENSION I:	**DIMENSION II:**	**DIMENSION III:**

Substance Use

Substance Of Abuse	Amount	Frequency	Route	Duration at this Rate	Date Last Used

Member Name:

Current Acute or Post-Acute Withdrawal Symptoms ***(check all that apply)***

□ **Nausea**	□ **Vomiting**	□ **Tremors**	□ **Anxiety**
□ **Irritability**	□ **Agitation**	□ **Diaphoresis**	□ **Disoriented**
□ **Headache**	□ **Restlessness**	□ **Mydriasis**	□ **Rhinorrhea**
□ **Lacrimation**	□ **Yawning**	□ **Piloerection**	□ **Diarrhea**
□ **Abdominal Cramps**	□ **Bone/Joint Aches**	□ **Tactile Disturbance**	□ **Auditory Disturbance**
□ **Visual Disturbance**			

□ **Other:** ***(Please Specify)***

Prior Substance Use Treatment History ***(please specify facility, dates, clean time after treatment)***

Treatment Plan and Orders:

MEDICATION				****DETOX MEDICATIONS**	
Medication	**Dosage**	**Route**	**Frequency**	****Date Started** *(N/A if not detox med)*	****Projected End Date** *(N/A if not detox med)*

Does Member Have Family/Informal Supports: □ **No** □ **Yes** ***(Please Specify Below)***	**Is There Existing Outpatient Care:** □ **No** □ **Yes** ***(Please Specify Below)***
List:	**List:**

Current living situation: **Able to Return?** □ **No** □ **Yes**	**Transportation to Appointments:**	**Pharmacy Name/Phone Number:**

Discharge and Aftercare Plan

(include provider member will be seeing upon discharge from this admission)