

<b>MEDICATION ASSISTED TREATMENT</b>
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<b>Provider:</b>		<b>Member ID:</b>	
<b>Review Date:</b>		<b>Reviewer Name:</b>	

1.	Does the member meet medical necessity for this service including the most appropriate level of care? <b>(Note: If question #1 scores 0, then all remaining questions score 0.)</b>	1	0
2.	Does the member have a diagnosis of Opioid Dependence for Suboxone or Alcohol Dependence or Opioid Dependence for Vivitrol that resulted from a physician assessment?	1	0
3.	Is there a current Coordination of Care agreement, including signature by all required parties (when required)?	1	0
4.	Is the member receiving the required amount of therapy per month (Phase I and/or Phase II) by appropriately credentialed staff?	1	0
5.	Is the member receiving the required amount of drug screens per month (Phase I and/or Phase II)? (*Drug screens must meet the policy minimum standard)	1	0
6.	Is the non-compliance policy enforced when the member has not been compliant with treatment or has not had successful drug screens?	1	0
7.	Is there documentation to support the frequency/intensity of services?	1	0

**Total Score= \_\_\_\_\_ [Possible 7]**