BACKGROUND
It is the goal of the Washington State Health Care Authority (HCA) to maximize opportunities for clients to receive effective and successful treatment for Substance Use Disorders. Substance Use Disorders are chronic remitting and relapsing diseases. Medicaid coverage of Medication Assisted Treatment (MAT) prescribed outside of traditional substance use disorder treatment programs increases the number of access points for treatment and provides patients with additional flexibility in managing their illness. Improving access to Medication Assisted Treatment for opioid use disorder is also important given what appears to be a transition from the high rates of prescription opioid use in Washington State to increasing rates of heroin use. In order to provide Community Health Plan of Washington (CHPW) enrollees with the widest range of treatment options, and with the recognition that substance use disorders are chronic conditions, CHPW will cover MAT products for the treatment of substance use disorders as an office based therapy, and allow indefinite continuation as maintenance treatment under the following conditions and recommended treatment protocols.

DEFINITIONS
None

INDICATIONS/Criteria
Intramuscular (IM) Naltrexone requires Prior Authorization. Providers are required to submit Medication Assisted Treatment Request and Release of Information (Form 13-331). See Appendix A.

CHPW will authorize Vivitrol® IM (Naltrexone) for members who have a diagnosis of moderate to severe opioid or alcohol use disorder and meet ONE of the following criteria:

- The enrollee has a co-occurring mental or behavioral health condition which impairs their ability to be compliant; or

- The enrollee has had unsuccessful treatment attempts with other Medication Assisted Therapies appropriate to their condition (acamprosate, oral naltrexone, or disulfiram for alcohol dependence or buprenorphine/naloxone, oral naltrexone); or
• In the past year, the enrollee has had three or more of the following:
  o Emergency room visits
  o Hospital admissions
  o Services for alcohol or drug related illness, injury or detoxification

For treatment of alcohol dependence, enrollee must have abstained from alcohol for 4 days prior to initiation of treatment. The efficacy of Vivitrol® IM (Naltrexone) in promoting abstinence has not been demonstrated in enrollee who have not completed detoxification and achieved abstinence prior to beginning treatment.

For qualifying enrollees, ALL of the following must be true:

• Must not be using opioid narcotics concurrently with naltrexone IM because of the potential to cause immediate and severe opioid withdrawal.
• Is receiving adequate psychosocial support for substance use disorder either directly from the prescriber, or as determined by the prescriber to be adequate to meet the enrollee’s needs through other available resources.

Dosage and Administration:
• Each IM injection (no more than 380mg/injection) is given no sooner than every 4 weeks.
• Injections are administered by a licensed healthcare professional in a medical facility.
• Treatment is limited to 6 doses in 24 weeks
• Extensions to be determined on case by case basis.

SPECIAL CONSIDERATIONS
Ongoing Treatment beyond six months: not a requirement for CHPW to approve the ongoing request for submission of the PA. This is the expectation that providers are doing this and HCA is responsible for oversight of this piece.

If treatment extends beyond six months, CHPW requires prescribers to complete a Medication Assisted Therapy Patient Status form and keep it in the enrollee’s medical record. For extension of treatment beyond the first six months and every six months thereafter, a new copy of the form must be completed and submitted with the prior authorization request form.

After the first six months of treatment and every six months thereafter:
• Urine drug screens can be performed at the discretion of the provider but must occur no less often than every six months.
• After six months, if the enrollee is stable, the Prescription Management Program (PMP) database must be checked at a minimum of every 6 months.
• Screens for depression and anxiety must be performed twice a year and documented in the health record, unless the enrollee is receiving treatment for either of these conditions in which case they should be repeated at the discretion of the provider.

LIST OF APPENDICES
Appendix A: Medication Assisted Treatment (MAT) Request form 13-331

LIMITATIONS/EXCLUSIONS
Please refer to a product line’s certificate of coverage for benefit limitations and exclusions for these services:

<table>
<thead>
<tr>
<th>PRODUCT LINE</th>
<th>LINK TO CERTIFICATE OF COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPLE HEALTH</td>
<td><a href="http://chpw.org/resources/Washington_Apple_Health_Benefit_Grid.pdf">http://chpw.org/resources/Washington_Apple_Health_Benefit_Grid.pdf</a></td>
</tr>
<tr>
<td>MEDICARE ADVANTAGE</td>
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REFERENCES
NCQA CITATION REFERENCES

http://www.hca.wa.gov/medicaid/pharmacy/Pages/ffs_drug_criteria.aspx

REVISION HISTORY

<table>
<thead>
<tr>
<th>REVISION DATE</th>
<th>REVISION DESCRIPTION</th>
<th>REVISION MADE BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/15/2015</td>
<td>New Clinical Coverage Criteria</td>
<td>Kelly Force; Yusuf Rashid, RPh</td>
</tr>
<tr>
<td>09/23/2015</td>
<td>Review and minor edits</td>
<td>Kate Brostoff, MD</td>
</tr>
<tr>
<td>01/20/2016</td>
<td>Approval</td>
<td>MMLT</td>
</tr>
</tbody>
</table>
**Appendix A**: Medication Assisted Treatment (MAT) Request form 13-331 (9/15)

**MEDICATION ASSISTED TREATMENT REQUEST FOR IM NALTREXONE**

**SECTION 1: Identification of client and providers**

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>ProviderOne ID</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
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<table>
<thead>
<tr>
<th>Phone number</th>
<th>If release is for information about dependent child(ren), name(s) of dependent child(ren)</th>
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<table>
<thead>
<tr>
<th>Physician name</th>
<th>NPI number</th>
<th>City</th>
<th>State</th>
<th>Physician’s phone number</th>
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<table>
<thead>
<tr>
<th>Pharmacy name</th>
<th>Pharmacy address</th>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
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**SECTION 2: Patient authorization for disclosure of confidential information**

The above-named patient hereby authorizes the following entities to exchange and disclose to one another information concerning the patient’s name and other personal identifying information, their status as a patient, diagnosis, recommended medication(s) and the treatment recommendation(s):

- The Health Care Authority (HCA)
- Any Managed Care Organization (MCO) contracted by HCA to provide your medical care
- The above named physician
- The above named pharmacy

The purpose of this authorization for disclosure is:

- To initiate an authorization to obtain a prescription and coordinate care.

I understand that my alcohol and/or drug treatment records are protected under Federal and State confidentiality regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: six (6) months from the date signed or the following specific date, event, or condition upon which this consent expires:

<table>
<thead>
<tr>
<th>Patient signature</th>
<th>Date</th>
<th>Guardian or authorized representative signature (if required)</th>
<th>Date</th>
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**SECTION 3: To be completed by prescriber only**

Patient meets criteria for diagnosis of moderate to severe opioid use disorder: 

- Yes
- No

Patient meets criteria for diagnosis of moderate to severe alcohol use disorder: 

- Yes
- No

Has the patient stopped drinking and established adequate abstinence to initiate treatment?* 

- Yes
- No

Has the patient been opioid-free long enough to avoid precipitation of severe opioid withdrawal? 

- Yes
- No

Has the patient had previous unsuccessful treatment attempts with oral naltrexone? 

- Yes
- No

Has the patient had a total of three or more emergency room visits, hospital admissions, or other medical services for alcohol or drug related illness, injury, or detoxification in the last 12 months? 

- Yes
- No

Does the patient have a co-occurring mental or behavioral health condition which impairs their ability to be compliant with an oral treatment? 

- Yes
- No

If yes, what is the diagnosis, and how does it interfere with treatment compliance? 

I have read and understand Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment (http://www.hca.wa.gov/medicaid/pharmacy/Pages/ftf_drug_criteria.aspx). I will complete form HCA 13-333 Medication Assisted Treatment Patient status if duration of treatment will be greater than six months.

<table>
<thead>
<tr>
<th>Prescriber signature</th>
<th>Prescriber specialty</th>
<th>Date</th>
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Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HCA 13-331 (EF5)