



MAT Provider Standards of Care Attestation

Fax this form to (888) 603-7696

APPLICATION PROCESS

Prescribers of office-based opioid treatment wishing to demonstrate compliance with Alaska Medicaid standards of care may complete and submit the Provider Attestation and Application for review to Magellan Medicaid Administration (see fax information above). Contact Magellan to start the review process and submit any additional required documents to Magellan. Magellan will inform you if you meet the requirements set forth in these criteria to be enrolled or credentialed as a Medicaid provider in their network. Attesting to meeting Alaska Medicaid standards of care criteria does not guarantee approval of the application.

CHECKLIST

- Physicians, Nurse Practitioners, Physician Assistants: completion of required training course hours.
Description of the roles and functions of the members of the prescriber's interprofessional team. Team members are not required to be co-located with the prescriber, but the prescriber must outline how she or he will ensure coordination with an individual's care team.
Description of how the prescriber provides or ensures interdisciplinary care coordination for patients.
Description of how treatment for co-morbid conditions (physical or mental health conditions) is provided as needed on-site or through collaboration with other providers, including recovery support.
Outline of network supports that are employed to ensure patients needing a higher level of care are appropriately referred.
Adherence to criteria outlined in Appendix.
Compliance with all state and federal laws.

Prescribers shall provide clinic protocol documents to demonstrate congruency with standards of practice.

PRESCRIBING/RENDERING PROVIDER

Last Name: First Name:
Prescriber NPI: Application Date:
State: License Type: MD APRN PA
License Number: Medicaid ID:
Prescriber Phone:

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Last Name: _____ NPI: _____

Application Date: _____

CLINIC (BILLING PROVIDER)

Clinic/Office Name: _____

NPI Number: _____ Medicaid ID: _____

Treatment Setting:

- | | |
|--|---|
| <input type="checkbox"/> Physician Office | <input type="checkbox"/> Specialty Clinic, Pain |
| <input type="checkbox"/> APRN Office | <input type="checkbox"/> Behavioral Health |
| <input type="checkbox"/> Outpatient Health System Clinic | <input type="checkbox"/> Other |
| <input type="checkbox"/> FQHC | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Primary Care Clinic | |

AFFILIATED CLINIC #1

Clinic/Office Name: _____

Clinic NPI: _____ Medicaid ID: _____

Treatment Setting:

- | | |
|--|---|
| <input type="checkbox"/> Physician Office | <input type="checkbox"/> Specialty Clinic, Pain |
| <input type="checkbox"/> APRN Office | <input type="checkbox"/> Behavioral Health |
| <input type="checkbox"/> Outpatient Health System Clinic | <input type="checkbox"/> Other |
| <input type="checkbox"/> FQHC | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Primary Care Clinic | |

AFFILIATED CLINIC #2

Clinic/Office Name: _____

Clinic NPI: _____ Medicaid ID: _____

Treatment Setting:

- | | |
|--|---|
| <input type="checkbox"/> Physician Office | <input type="checkbox"/> Specialty Clinic, Pain |
| <input type="checkbox"/> APRN Office | <input type="checkbox"/> Behavioral Health |
| <input type="checkbox"/> Outpatient Health System Clinic | <input type="checkbox"/> Other |
| <input type="checkbox"/> FQHC | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Primary Care Clinic | |

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Last Name: _____ NPI: _____

Application Date: _____

INTERPROFESSIONAL TEAM

1. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

2. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

3. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

4. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

5. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

6. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

7. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

8. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

9. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

10. Name: _____ NPI (10 digits): _____

Phone Number: _____ Fax Number: _____

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Last Name: _____ NPI: _____

Application Date: _____

ATTESTATION

I hereby certify that all information contained in this document is true and accurate. I further understand that any information entered in this document that subsequently is found to be false may result in termination of any agreement that I have or may enter into with Alaska Medicaid and/or its contractors. I agree to update the information contained herein at least annually or sooner if things change.

I hereby give permission and consent for Alaska Medicaid and/or its contractors to obtain and verify information provided in this form; consent to the release by any person, organization, or other entity to Alaska Medicaid and/or its contractors of all information relevant to the evaluation of my ability to render treatment services in a cost-effective manner and my moral and ethical qualifications; and agree to hold harmless any such person or organization from any cause of action based on the release of such information to Alaska Medicaid and its contractors.

By signing this attestation, I agree that all statements are true and agree to abide by any contracted requirements for the services delivered under the authority of this agreement. I understand that any intentional misrepresentation may result in possible actions against my Alaska Medicaid enrollment as outlined in 7AAC105.400-490.

Prescriber Signature: _____ **Date:** _____
(required)

Prescriber Initials: _____ I hereby agree to comply with the current [MAT Standards of Care](#) criteria document published at as well as all relevant state and federal laws and regulations when prescribing buprenorphine-based products in the context of medication assisted therapy.

Prescriber Initials: _____ I hereby agree that the use of single agent buprenorphine will be reserved for pregnant women.

Magellan Medicaid Administration, PA Unit
14100 Magellan Plaza
Maryland Heights, MO 63043
Phone: (800) 331-4475

Fax this form to (888) 603-7696

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APPENDIX: BUPRENORPHINE-BASED MEDICATION ASSISTED THERAPY OFFICE-BASED OPIOID TREATMENT

Opioid dependency treatment and pathways to recovery demonstrate the highest persistence of opioid misuse avoidance when comprehensive treatment strategies are available to individuals. Integration of counseling and behavioral health treatment with opioid partial agonists is evidence-based and required under federal law. For individuals who opt for treatment with buprenorphine-based medication assisted therapy, (1) accessibility, (2) comprehensiveness, (3) coordination, and (4) continuity are critical components.

Accessibility

- Patient-centric MAT options
- Management of barriers to treatment
- Initial and follow-up care available

Comprehensiveness

- MAT
- Integration of behavioral health services
- HIV/Hep C screening and treatment
- Family-planning options
- Prenatal care
- Co-morbid conditions
- Family engagement
- Education
- Harm reduction, self-care

Coordination

- Primary care, other care providers
- Specialty or other service referral person
- Level of care escalation referral person
- Connection with social supports (e.g., housing, education, etc.)
- Peri-procedure treatment planning coordination

Continuity

- Patient-centric treatment plan¹, including care management
- Team emphasis
- Exit/re-entry protocols

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Drug Enforcement Agency (DEA) Drug Addiction Treatment Act (DATA) 2000 waived prescribers opting to prescribe buprenorphine-based medication assisted treatment for Medicaid members shall conform to the minimum standards of care outlined in this document. Prescribers may demonstrate conformation with these standards of care either by (1) presenting prior authorization requests for each individual member being prescribed buprenorphine-based products beyond the first 28 days of therapy or (2) satisfactorily completing the above attestation form and committing to at least the minimum standards of care throughout the authorized period. Prescriptions filled during the prescriber's 12-month authorization period will not require separate individual prior authorizations. Prescribers who fail to maintain conformation with the minimum standards of care outlined in this document will be required to present prior authorization requests for individual members until such time as the prescriber is able to resolve any relevant deficiencies.

Preferred Medication

Refer to the Preferred Drug List available on Alaska's [Medication Prior Authorization](#) page.

Indication

Opioid dependence in individuals at least 16 years old

Criteria for Approval

Patients new to buprenorphine-based medication assisted therapy (MAT) within the most recent 60 days will not require prior authorization when initiating therapy. To ensure prescribers are adhering to best-practice principles, prescribers must seek prior authorization for continuation of therapy and ensure the following criteria are met:

1. The prescriber attests to maintaining authorization to prescribe buprenorphine treatment for opioid dependency, meets all qualifications (State and Federal; e.g., DATA-certified), has been issued a special identification number from the Drug Enforcement Administration, and may not accept cash payments from Medicaid members; **AND**
2. Patient and prescriber have a defined MAT treatment plan (including functional goals) and projected timeline on record; **AND**
3. Patient is receiving regular psychosocial support; **AND**
4. Maximum dose of buprenorphine less than or equal to:
 - Buprenorphine (Suboxone, Subutex) – 24 mg/day
 - Buprenorphine (Zubsolv) – 17.1 mg/day (two 8.6 mg tablets)
5. Single ingredient oral buprenorphine products (e.g., Subutex) are restricted to pregnant females.

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Prescriber Responsibilities

1. If buprenorphine prescriber is not providing psychosocial support to the patient, the MAT-prescriber maintains a coordinated shared care plan with another practitioner and maintains copies of the care plan with both practitioners; **AND**
2. Prescribers are responsible for routinely screening patients for anxiety and mental health challenges and providing supportive access to care.
3. If the patient has chronic pain, the prescriber develops a patient-centric defined treatment plan that optimizes non-opioid therapies in order to manage chronic pain in the absence of opioids.
4. Patients are encouraged to enroll in the AMCCI program; prescribers may refer patients.
5. Prescribers are responsible for requesting prior authorization for continuation of therapy in sufficient time to avoid patients not having access to medically necessary treatment.
6. Prescribers are responsible for maintaining an up-to-date treatment plan and reviewing at least every six months with the patient. Trial tapers to lower maintenance doses should be considered when the patient has been stabilized and the patient demonstrates readiness.

Criteria Resulting in Denial

1. The patient is 15 years old or younger; **OR**
2. The patient is being treated for anything other than opioid dependence; **OR**
3. The patient has not agreed to adhere to a treatment plan; **OR**
4. The prescriber does not meet all qualifications to prescribe buprenorphine-based products for opioid dependence; **OR**
5. Any concomitant prescriptions for other opioids while patient is receiving an oral buprenorphine product for MAT will be denied

Length of Authorization

1. If the prescriber has successfully completed the Standards of Care Attestation application, prescriptions filled during the prescriber's 12-month authorization period will not require separate individual prior authorizations.
2. Until a prescriber has successfully completed the attestation for the Standards of Care, individual patient prior authorization may be authorized for up to six (6) months. After 6 months, a new prior authorization may be obtained.

Dispensing Limit

The dispensing limit is a 34-day supply of medication.

Maximum Daily Dose

Daily doses exceeding the following will be prior authorized:

- Buprenorphine (Suboxone, Subutex) – 24 mg/day (three 8 mg films)
- Buprenorphine (Zubsolv) – 17.1 mg/day (two 8.6 mg tablets)

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Regulatory Authority

Alaska Medicaid prior authorization clinical criteria for use and standards of care are developed under the authority granted to the Alaska Medicaid Drug Utilization Review Committee in compliance with 7 AAC 120.120, 7 AAC 120.130, 7 AAC 120.140, 42 USC 1396r-8, and 42 CFR 456 Subpart K. The Committee considers each of the following in the development of clinical criteria for use as outlined in 7 AAC 105.230(c): medical necessity, clinical effectiveness, cost-effectiveness, and likelihood of adverse effects as well as service-specific requirements. Drugs which fall into a specific therapeutic category but are approved by the FDA after the most recent revision of that therapeutic drug class review will be subject to the same standards set by DUR Committee for the relevant therapeutic category's prior authorization clinical criteria for use. This includes a requirement to utilize or trial preferred agents prior to the utilization of a non-preferred agent within a given therapeutic category unless a documented clinical contraindication exists. Covered outpatient drugs must meet the parameters defined in 7 AAC 120.110. Drugs which the FDA has approved but clinical benefit has not been established will not be approved.

References

1. Alaska Administrative Code. 12 AAC 40.975. Prescribing controlled substances.
2. Mullin D, Martin S. Primary Care of Patients with Opioid Use Disorder (slide presentation). Presented at Alaska Primary Care Association. 2017.
3. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, PEP18: Treatment Locator, available at <https://store.samhsa.gov/product/Finding-Quality-Treatment-for-Substance-Use-Disorders/PEP18-TREATMENT-LOC>.
4. Center for Substance Abuse Treatment. Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.