Urine Drug Screen
Prior Authorization Request for Quantity Limit Exceptions

Utah Medicaid policy aligns with the American Society of Addiction Medicine (ASAM) guidelines that encourage individualized, medically necessary urine drug testing, with more frequent testing early in recovery and less frequent testing as the patient becomes more stable.

Court ordered drug testing without a medical indication, or routine screening/blanket ordering of testing at defined intervals, are not indications of medically necessary drug testing.

Instructions

- Ordering clinician to complete this form fully and legibly. All fields with an asterisk (*) are required.
- For questions, call **(801) 538-6155** or toll free **(800) 662-9651** and select options **3, 3, 6.**
- Submit the completed form for requested service to one of the options below:

Fax: 801-536-0162
Email: fax_allotherauth_prior@utah.gov

Address: Utah Medicaid Prior Authorization
PO BOX 14311
Salt Lake City, UT 84114-3111

Member Information

1. Name (First, Middle Initial, Last):*		2. Medicaid ID#:*
3. Date of Birth:*	4. Age:*	5. Gender: ☐ Female ☐ Male
6. Has eligibility been verified? * https://medicaid.utah.gov/eligibility/ ☐ No ☐ Yes		
7. Is the member enrolled in a managed care entity (MCE)? * ☐ No ☐ Yes, contact member's MCE		

Provider Information

8. Requesting Provider:*	9. NPI:*
10. Address:*	
11. Contact person:*	12. Phone #:*
13. Contact information:* Fax #: Or Email address:	

Request Information

14. Date of submission: *	15. Requested date(s) of service:*
16. Total pages:	17. Request a change to a previous PA?* ☐ No ☐ Yes, Previous PA#:
18. Is this a retroactive request? * ☐ No ☐ Yes, list reason (Required if "Yes"):	
19. Reason for request? * ☐ Substance Use Disorder treatment ☐ Chronic pain management ☐ Other: _____	
20. Patients current phase of care? * ☐ Engagement ☐ Early Recovery ☐ Maintenance ☐ Long term maintenance ☐ Relapse	

21. Service(s) *	22. CPT/HCPCS code* with Units Requested			
☐ Presumptive test (limited to 8/30-day period)	☐ 80305	☐ 80306	☐ 80307	
☐ Definitive test (limited to 1/30-day period)	☐ G0480	☐ G0481	☐ G0482	☐ G0483

23. Attestation* (No additional documentation required for prior authorization, but case records may be subject to post-payment review.)

- ☐ Patient has experienced a change in circumstance that necessitates increased frequency of testing. Examples include: recent relapses, changes in ASAM level of care, changes in MAT dosing, life event (e.g. any high-risk relationship event; anniversary of important events, etc.)
- ☐ Current treatment plan clearly addresses the above changes in circumstances and justifies the increased need for drug testing
- ☐ Opioid agreements and/or informed consent in place, if applicable
- ☐ Documentation of checking the controlled substance database with every drug test visit, if applicable
- ☐ Requested test meets the necessary type of test based on patient prescription drug history including MAT, OTC meds, and drug of abuse

24. Additional Information

Prior authorization does not guarantee reimbursement. All other Medicaid requirements must be met in order for a provider to receive reimbursement. Information contained in this form is Protected Health Information under HIPAA.