



7.3.4 MEDICATIONS FOR ADDICTION TREATMENT SERVICES

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References: Behavioral Health Information Notice (BHIN) 23-054; CA H&SC Sections 11832.9(c) and 11834.28(c); Code of Federal Regulations (CFR) 42 8.12; Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS), multi-year 2023-2027 and subsequent versions

Policy Owner: Behavioral Health Division, Quality Assessment and Performance Improvement (QAPI), Quality Assurance Manager

Director Signature: **Signature on File**

I. Policy Statement

Sonoma County Department of Health Services – Behavioral Health Division (DHS-BHD), Substance Use Disorder (SUD) and Community Recovery Services Section will comply and adequately provide Medications for Addiction Treatment (MAT) services, or facilitate effective referrals to MAT service providers. In accordance with state and federal regulations, Medi-Cal members will be able to access MAT services within established timeframe and distance standards.

II. Scope

This policy applies to all DHS-BHD Covered Persons including employees (full-time, part-time, extra-help), unpaid interns, paid interns, temporary agency workers, registered volunteers, and all individual providers contractually designated as Covered Persons. Covered Persons do not include Community Based Organization (CBOs) staff.

III. Definitions

A. American Society of Addiction Medicine (ASAM) Interview Guide: The nation's most widely used and comprehensive set of guidelines for patient placement,

continued stay, transfer, and discharge of patients with addiction and co-occurring conditions. The ASAM Criteria includes six dimensions used to assess SUDs and determine appropriate service levels of care, from early intervention through medically managed intensive inpatient services. The use of ASAM Criteria is required for participation in the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.

B. A Member is a person who:

1. Has been determined to be eligible for Medi-Cal.
2. Is not institutionalized.
3. Has a substance-related disorder as per the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria.
4. Meets the admission criteria to receive Drug Medi-Cal (DMC) covered services.

C. Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition (DSM-5): The 2013 update to the DSM, the taxonomic and diagnostic tool published by the American Psychiatric Association. In 2022, a revised version was published.

D. Discharge Planning: Is the process of preparing a member for referral to another level of care, post-treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and other supportive services.

E. Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan: The Prepaid Inpatient Health Plan (PIHP) operating in Sonoma County serving eligible residents by providing automatic and mandatory enrollment of Medi-Cal members. It is defined by a state-county contract partnership between the California Department of Health Care Services (DHCS) and Sonoma County.

F. Evidence-Based Practices (EBPs): Interventions that have been shown to be effective and are supported by evidence. In the provision of DMC-ODS Waiver services, SUD contracted service providers utilize EBPs that have undergone stringent evaluation and meet clinical standards.

G. Intake: Intake is the process of determining whether a member meets the medical necessity criteria, and, if the criteria are met, the member is admitted into a SUD treatment program. Intake includes the evaluation or analysis of the cause or nature of the mental, emotional, psychological, behavioral, and substance use disorder, as well as the assessment of treatment needs, to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.

- H. Licensed Practitioners of the Healing Arts (LPHA): Includes any of the following: licensed physicians, licensed psychologists (including waived psychologists), licensed clinical social workers (including waived or registered clinical social workers), licensed professional clinical counselors (including waived or registered professional clinical counselors), licensed marriage and family therapists (including waived or registered marriage and family therapists), registered nurses (including certified nurse specialists and nurse practitioners), licensed vocational nurses, licensed psychiatric technicians, and licensed occupational therapists.
- I. Medications for Addiction Treatment / Medication-Assisted Treatment (MAT): An evidence-based practice, which combines pharmacological interventions with substance abuse counseling, and behavioral therapies for the treatment of SUDs.
- J. Network Provider: An individual, group, or organization that is contracted to provide mental health and/or substance use treatment services to Sonoma County Medi-Cal members under contract with Sonoma County's DHS-BHD as part of the County's Mental Health Plan (MHP) or DMC-ODS plan.
- K. Opioid (Narcotic) Treatment Program (OTP): Is an outpatient clinic licensed by the state to provide narcotic replacement therapy aimed at the stabilization and rehabilitation of individuals who are opiate-addicted and have a substance use diagnosis.
- L. Pronoun Usage: Throughout this policy, the singular "they/their" is used as a gender-neutral pronoun to promote clarity, readability, and inclusivity.
- M. Release of Information (ROI): A document that gives a consumer the opportunity to decide what materials they want released from their medical file, who they want it delivered to, how long the data may be issued, and under what statutes and guidelines it is released. A ROI also allows for protection of both the consumer and the provider when releasing Health Insurance Portability and Accountability Act (HIPAA) information.

IV. Policy

A. Intake:

The DHS-BHD does not provide MAT services directly to members but provides an effective referral process to Narcotic Treatment Programs (NTPs), community health centers, or other MAT providers to ensure appropriate referral through their insurance carrier. The referral process is initiated through an intake assessment.

The DHS-BHD SUD staff conduct a thorough intake assessment on all prospective members to determine their need for MAT services. All prospective

members are screened using the ASAM Interview Guide, DSM-5 criteria for Opioid Use Disorder (OUD), and the Client Health Questionnaire and Initial Screening Questions (CHQ). The Client Health Questionnaire and Initial Screening Questions (DHCS 5103) form will be used to document which MAT services were offered directly to the member, or if the member was referred to a MAT provider.

B. Risks And Benefits of Medication for Addiction Treatment:

1. DHS-BHD SUD is compliant with providing members with information about the benefits and risks of MAT.

The benefits and risks of MAT will be provided and documented by a counselor or LPHA in a Progress Note within the member's profile in the Electronic Health Record (EHR) System. Documentation will include evidence of the member's assessment for MAT services, a member's acceptance or refusal of the referral to MAT services, and a history of the use of MAT services. The benefits and risks of MAT will be minimally provided to the member at intake and after 1-year of treatment. Members may be provided with the benefits and risks of MAT again, when usage is exacerbated/worsened, or when clinically indicated.

There are many resources available in the public domain for facilities to provide members with information about MAT, including:

- a. The California MAT Expansion website houses resources for members and providers related to MAT options. Resources include member-facing materials, such as flyers in English and Spanish.
- b. The Substance Abuse and Mental Health Services Administration (SAMHSA) has a dedicated page about Medications for SUDs.
- c. The National Institute on Drug Abuse (NIDA) has resources, including an infographic about Medications for Opioid Overdose, Withdrawal & Addiction, and a video about Medications for OUD.
- d. The American Society of Addiction Medicine (ASAM) has a published Opioid Addiction Treatment pocket guide which provides information for members, families and friends.

C. Medications for Addiction Treatment Referral Policy:

1. DHS-BHD SUD does not provide Detoxification or Medication Services for Medication-Assisted Treatment. If it is determined that a member needs services, a referral for services will be necessary.

2. DHS-BHD SUD and referring facilities shall not deny admission to members who have valid prescription for a medication (MAT).

D. Pharmacology:

1. In general, the choice of medication used in medication-assisted treatment (MAT) for opioid addiction, is based on safety and efficacy, patient preferences, and treatment goals. Methadone maintenance treatment has the longest successful track record in patients addicted to opioids for more than a year and has been shown to control withdrawal symptoms, stabilize physiologic processes, and improve functionality. Sublingual buprenorphine formulations have been approved for use in OTPs and by physicians in office-based and other health care settings. Some patients prefer buprenorphine maintenance in an office-based opioid treatment (OBOT) setting to the daily observed dosing that is part of methadone maintenance in an OTP.

E. Collaboration with Medical Providers:

1. DHS-BHD SUD shall maintain a MAT Provider Network, to address the needs of members.

DHS-BHD SUD will maintain a list of approved medical providers who are qualified in experienced in prescribing and managing MAT. Program staff will coordinate care with these providers

F. Medication monitoring, storage, and disposal of MAT medications:

1. **DHS-BHD SUD does not prescribe, administer, or store medications at the facility.**

If a member arrives at the facility with their medication, the member will be responsible for storing the prescribed MAT.

G. MAT Staff Training Requirements:

1. All program staff involved in MAT services must complete the initial training on the benefits and risks of MAT and the MAT policy to gain a comprehensive understanding of the treatment modality. Training will be provided by an Alcohol and Drug Program Specialist (AODS) or Health Program Manager who is licensed as an LPHA or certified as a drug use counselor, with a minimum two years' experience providing direct patient care to patients receiving MAT. The training will cover the following areas:
 - a. An overview and understanding of the facility's MAT policy.
 - b. An overview of MAT, including its benefits, limitations, and evidence-based practices. Specifically review Medications for OUD: Treatment Improvement Protocol 63 sections 1, 4, and 5.

- c. Best practices for member assessments, treatment planning, and referrals of members on MAT.
- d. Regulations, policies, and ethical considerations related to MAT provision.
- e. Completing recommended online training through NAADAC, Change Companies, CEU4less, or other approved online substance use education programs.
- f. Attending the recommended local training events offered through Sonoma County Behavioral Health.
- g. How to enroll in the MAT Certification Program, and submit for MAT Certification to become MAT Certified Counselor (optional for program staff)

H. Documentation:

- 1. DHS-BHD SUD will maintain documentation of each substance use provider's completion of initial MAT training and any ongoing continuing education. All staff will complete training upon hire, annually, or as otherwise indicated. Behavioral Health Program Manager will store documentation in an employee personnel file.

I. Quality Improvement:

- 1. The organization will regularly review and assess the effectiveness of its MAT training policies and referral practices and make appropriate revisions as needed.

V. Procedures

A. Intake:

- 1. The initial assessment shall be performed face-to-face, by telehealth (“telehealth” is defined as synchronous audio and video) or by telephone (synchronous audio-only).
- 2. The evidence-based assessment shall be performed by a LPHA or registered or certified counselor within the first twenty-four (24) hours of admission.
 - a. If the assessment of the member is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

3. If the evidence-based assessment indicates that MAT would be beneficial for the member, the member is referred to an approved MAT.
 - a. If DHS-BHD is unable to meet network adequacy requirements and the provider network is unable to provide timely access to necessary services within the applicable time and distance standards, DHS-BHD will adequately and timely cover these services by working to secure an out-of-network provider for the member. DHS-BHD will permit out-of-network access for as long as the DHS-BHD provider network is unable to provide the services in accordance with the standards.

B. MAT Referrals:

1. Referral Process

- a. An appropriate referral to an agency that provides MAT services will be made upon initial assessment to the program using the SUD MAT Service Referral Form. Protocol for timely referrals is within 24 hours of request for MAT. DHS-BHD SUD-OPT will refer to a minimum of three MAT locations that provide FDA approved medications for SUD / MAT services, which may include assessment; care coordination; counseling (individual and group counseling); family therapy; medication services; patient education; prescribing and monitoring MAT for OUD and Alcohol Use Disorder (AUD) and non-opioid SUDs which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD, AUD and non-opioid SUDs; recovery services; SUD crisis intervention services; and withdrawal management services.
 - i. The Interviewing Counselor will provide a MAT referral form for each member requesting services that outline the DSM, Fifth Edition criteria for OUD. The referral form contains complete contact information for 3 local agencies, including name, address, phone number, website, distance from the facility and type of medication provided.
- b. Provide the member with a list of recommended medical providers for MAT, taking into consideration their insurance coverage, location, and treatment preferences. *See Attachment 1
- c. Assist the member in scheduling an initial appointment with the referred medical provider. If telehealth is available, work with the telehealth provider to schedule appointments with the case manager to address the member's needs and the available pharmacy for medication pick-up or delivery.
- d. Assist the member in obtaining transportation to and from the appointment. Transportation to and from MAT services will be provided by

insurance benefits or DHS-BHD SUD-OPT will provide transportation if available.

- e. Sonoma County has two locally available Narcotic Treatment Programs (NTPs) for patient referral: Redwood Empire Addictions Program (REAP) and a Santa Rosa Treatment Program (SRTP). Sonoma County has a referral network of Federally Qualified Health Centers (FQHC).
- f. The Interviewing Counselor will provide a MAT referral form for each member requesting services that outline the DSM, Fifth Edition criteria for OUD (SAMHSA, 2021). All contact information is available on their resources sheet given to them at admit and is available any time during treatment, or at discharge, even if member initially declined the referral.
- g. DHS-BHD SUD staff will obtain a ROI, and then call and connect the member with the staff at one of the collaborative agencies. Members are encouraged to establish services within 3 business days of request or prior to admission, when possible, if the information is given to the member at screening.
- h. If services are already established with a provider, DHS-BHD SUD staff will call (at intake) and inform the provider that the member is at DHS-BHD SUD-OPT and arrangements will be made to continue their services, including transportation to and from the provider, as needed. Out of County members can receive courtesy dosing through SRTP or DAAC REAP and can be set up prior to their admission date. Similarly, members who are in the custody of the Sonoma County Jail will receive courtesy dosing as well.

C. Procedures for Accessing Buprenorphine:

1. General Information

- a. Buprenorphine, an opioid receptor partial agonist, is a schedule III-controlled medication derived from the opium alkaloid thebaine. The FDA approved buprenorphine on October 8, 2002, for use in medical maintenance treatment and medically supervised withdrawal. Through cross-tolerance and mu-opioid receptor occupancy, at adequate doses, buprenorphine reduces opioid withdrawal and craving and blunts the effects of illicit opioids. Buprenorphine binds tightly to the mu-opioid receptor because of its particularly high receptor affinity. This prevents other opioids with lower affinity (e.g., heroin) from binding. The net result is a blunting or blocking of the euphoria, respiratory depression, and other effects of these opioids. Because it is a partial agonist at higher doses, buprenorphine also can precipitate opioidlike withdrawal symptoms in patients with high levels of physical dependence on opioids, making it

appear to function more like an antagonist under these conditions (SAMHSA, 2012).

2. Dosage form: Buprenorphine is available in sublingual tablets containing either buprenorphine alone (sometimes called monotherapy tablets and marketed under the name Subutex) or combined with naloxone (called combination therapy tablets with the trade name Suboxone). Buprenorphine is also available as a subcutaneous injectable.
3. Efficacy: The primary efficacy of buprenorphine in clinical trials was demonstrated via patient retention and elimination of illicit-opioid- positive drug tests. Compared with equipotent doses of both methadone and LAAM, buprenorphine produced similar rates of treatment retention and abstinence from illicit opioids. In a controlled, randomized study comparing the efficacy of LAAM (75 to 115 mg), buprenorphine sublingual solution (16 to 32 mg), and methadone (60 to 100 mg), all three medications substantially reduced illicit opioid use (SAMHSA, 2021). Johnson and colleagues reviewed numerous studies evaluating the efficacy of buprenorphine for maintenance treatment lasting up to 1 year. These studies have shown that daily doses of 8 mg of sublingual solution or 8 to 16 mg of the buprenorphine tablet are safe and well tolerated. Most studies comparing buprenorphine and methadone have shown that 8 mg of sublingual buprenorphine or 16 mg of the tablet per day is equivalent to approximately 60 mg of oral methadone per day (SAMHSA, 2021).
4. Risks/Benefits: Buprenorphine is contraindicated in patients who are allergic to it. Patients with true allergic reactions to naloxone should not be treated with the combination buprenorphine/naloxone product. Allergy to naloxone is infrequent.
 - a. Respiratory depression and overdoses are uncommon in adults, but they do happen. Most fatal overdoses involve IV buprenorphine misuse or concurrent central nervous system depressant use, including high doses of benzodiazepines, alcohol, or other sedatives (SAMHSA, 2012). However, fatal overdoses have been reported in opioid-naïve patients treated with 2 mg buprenorphine for pain. Unintentional pediatric exposure can be life threatening or fatal (SAMHSA, 2012). Thus, emphasize safe storage of medication, and teach patients to remove any buprenorphine found in a child's mouth immediately. Call 9-1-1 so the child can go to the nearest emergency department for immediate medical attention.
 - b. Cases of hepatitis and liver failure exist but often involve predisposing hepatic risk factors, such as preexisting liver enzyme abnormalities, hepatitis B or C infections, and use of other potentially hepatotoxic drugs or IV drugs. A multisite randomized trial of hepatic effects in patients taking methadone or buprenorphine found no evidence of liver damage in the first 6 months of treatment. The authors concluded that prescribing

these medications should not cause major concern for liver injury (SAMHSA, 2012).

- c. Adrenal insufficiency has been reported with opioid use, most often after more than 1 month of buprenorphine maintenance (SAMHSA, 2012).
 - d. Patients will develop physical dependence on buprenorphine. Alert patients that they'll experience opioid withdrawal if they stop buprenorphine.
 - e. Buprenorphine may affect cognition and psychomotor performance and can have sedating effects in some people (particularly those who've lost tolerance after a period of abstinence from opioids). Concurrent use of illicit drugs, other prescribed medications, or medical or psychiatric comorbidity can affect cognition and psychomotor performance. Urge patients to exercise caution in using heavy machinery and driving until they're sure that their abilities are not compromised.
 - f. Neonatal abstinence syndrome (NAS) may occur in newborns of pregnant women who take buprenorphine. Women receiving opioid agonist therapy while pregnant should talk with their healthcare provider about NAS and how to reduce it. Not all babies born to women treated with opioid agonists require treatment for NAS.
5. Locally available buprenorphine providers can be found on Attachment 1 below or through use of the Substance Abuse and Mental Health Services Administration (SAMHSA) Buprenorphine practitioner locator (<https://samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator>).
6. Care Coordination
- a. A clinical consultation call will be completed within 10 business days to review current service needs and facilitate the transfer of care. Upon completion of the clinical consultation, the receiving primary contact will initiate contact with the member within 10 business days to engage services.
 - i. Referrals to MAT services are made within 24-hours of a request for MAT services.
 - b. Upon successful engagement of the member, the receiving primary contact will enroll the member onto the treatment team and inform the referring primary contact, who will then close services with the referring treatment team.

- i. Until the member has attended the first service appointment with the new provider, the referring treatment team is responsible for providing on-going care.
- c. For additional care coordination policy and procedure requirements, review Care Coordination Policy, and Care Coordination Procedures.

D. Procedures for Accessing Methadone:

1. General Information

- a. The synthetic opioids methadone and Levo-alpha-acetyl-methadol (LAAM) are the only long-acting full opioid agonists approved for opioid pharmacotherapy. Opioid agonists bind to the mu-opioid receptors on the surfaces of brain cells, which mediate the analgesic and other effects of opioids. Methadone and LAAM produce a range of mu agonist effects similar to those of short-acting opioids (SAMHSA, 2012). Therapeutically appropriate doses of these agonist medications produce cross-tolerance for short-acting opioids such as morphine and heroin, thereby suppressing withdrawal symptoms and opioid craving as a short-acting opioid is eliminated from the body. The dose needed to produce cross-tolerance depends on a patient's level of tolerance for short-acting opioids.
 - b. When given intramuscularly, or orally, methadone suppresses pain for 4 to 6 hours. Intramuscular methadone is used only for patients who cannot take oral methadone, for example, patients in medication-assisted treatment for opioid addiction (MAT) who are admitted to a hospital for emergency medical procedures. Methadone should not be given parenterally in an OTP.
 - c. After patient induction into methadone pharmacotherapy, a steady-state concentration (i.e., the level at which the amount of drug entering the body equals the amount being excreted) of methadone usually is achieved in 5 to 7.5 days (four to five half-lives of the drug). An adequate daily oral dose of methadone suppresses withdrawal and drug craving for 24 to 36 hours in most patients who are opioid addicted.
- 2. Dosage form: Methadone is provided in various forms, including diskettes, tablets, oral solution, liquid concentrate, and powder. In the United States, methadone used in MAT almost always is administered orally in liquid form.
 - 3. Efficacy: Numerous clinical trials and meta-analyses have shown that methadone treatment is associated with significantly higher rates of treatment retention and lower rates of illicit opioid use compared with placebo and with no treatment. Other research associate's methadone treatment with reduced mortality, criminal behavior, and HIV seroconversion (SAMHSA, 2021). A Cochrane meta-analysis found that, at flexible doses, methadone compared

with buprenorphine retains patients in treatment significantly longer and equally reduces illicit opioid use (SAMHSA, 2021). Maintenance treatment typically leads to reduction or cessation of illicit opioid use and its adverse consequences, including cellulitis, hepatitis, and HIV infection from use of nonsterile injection equipment, as well as criminal behavior associated with obtaining drugs. Methadone pharmacotherapy has been shown to lead to improved overall adjustment, including reductions in psychiatric symptoms, unemployment, and family or social problems.

4. Risks/Benefits: The most common adverse effects reported by patients receiving methadone are constipation, sweating, nausea, sexual dysfunction/decreased libido, drowsiness, amenorrhea, weight gain, or edema (SAMHSA, 2012).
5. Methadone can cause respiratory depression, particularly during initial dosing and dose titration. The goal of methadone dosing in the first weeks of treatment (i.e., induction) is to relieve withdrawal but avoid oversedation and respiratory depression (SAMHSA, 2021).
6. Overdose and death can occur if methadone is taken in larger amounts than directed and in amounts exceeding patients' tolerance levels. Unintended, possibly lethal respiratory depressant effects also can occur if these medications are used in combination with substances that depress the central nervous system, such as alcohol and benzodiazepines (SAMHSA, 2012).
7. Locally available buprenorphine providers can be found on Attachment 1 below or through use of the Substance Abuse and Mental Health Services Administration (SAMHSA) Buprenorphine practitioner locator (<https://samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator>).
8. Care Coordination
 - a. A clinical consultation call will be completed within 10 business days to review current service needs and facilitate the transfer of care. Upon completion of the clinical consultation, the receiving primary contact will initiate contact with the member within 10 business days to engage services.
 - i. Referrals to MAT services are made within 24-hours of a request for MAT services.
 - b. Upon successful engagement of the member, the receiving primary contact will enroll the member onto the treatment team and inform the referring primary contact, who will then close services with the referring treatment team.

- i. Until the member has attended the first service appointment with the new provider, the referring treatment team is responsible for providing on-going care.
 - c. Plan for safe storage/protocols for continuation of MAT
 - d. For additional care coordination policy and procedure requirements, review the DHS-BHD Policy No. 7.1.12, *Coordination of Care*.
- E. Collaboration with Medical Providers:

Collaboration with medical providers will occur at intake, at discharge, and as medically necessary.

1. Coordination of Care

- a. Maintain ongoing communication and collaboration with the referred medical providers to facilitate the coordination of care.
- b. Share relevant member information, problem areas, strengths, barriers and progress updates with the medical provider to ensure holistic and integrated care for the member.
- c. Respect member privacy and strictly adhere to applicable confidentiality regulations when sharing information.
- d. Work with MAT provider to ensure ongoing care for members while in treatment services, and address continuum of care for members after discharge.
- e. Work with members and MAT provider to address concerns related to side-effects, continued cravings, concerns, and effectiveness of MAT to ensure quality care, and to improve treatment outcomes.
- f. Meet coordination of care policy and procedure requirements specified in Policy No. 7.1.12, *Coordination of Care*.

2. Discharge Planning

- a. Maintain ongoing communication and collaboration regarding counseling and program status to facilitate continued care after completion of residential or outpatient care.
- b. Share information regarding discharge dates, level of care changes, members' location after treatment, and assist in aftercare plan with MAT provider
- c. Schedule initial aftercare appointment prior to scheduled discharge.

- d. If a member is relocating, continue collaboration with the member and MAT provider to identify a new provider and facilitate the ROI with the MAT provider. Work with the current provider to obtain a refill of MAT medications or take-home doses from the NTP. Assist in scheduling appointments with the new provider.
3. Monitoring and Follow-up
- a. Regularly follow up with members receiving MAT during individual sessions to assess their progress, treatment adherence, and any potential concerns or side effects.
 - b. Counselors will assist with coaching for the safe storage of medications during transport and at home, while in an outpatient setting. For example: use childproof containers as needed, have a sober partner or support person hold onto medications if needed, for dispensing or locking; etc.
 - c. Confirm the member is taking medications as prescribed, by observing them for potential side effects or concerns that need to be reported to NTP/MAT program.

VI. Forms

- A. DHCS 5103 – Client Health Questionnaire and Initial Screening Questions
- B. Medications for Addiction Treatment Services Referral Form

VII. Attachments

None