Mandatory Annual Report Due for all 275 Patient Waivered Practitioners

Response ID:4796 Data

This response is *EXAMPLE*data.

1. Instructions

This information should be submitted for SAMHSA review by completing this electronic form.

For items 1-8, please enter the information as requested.

For item 9, please enter the 2-digit month and 4-digit year for the both the beginning and ending months of the 12 month period on which you are reporting.

For item 10a, please enter the 2-digit month and number of patients to whom you prescribed or dispensed covered medications for each of the 12 months on which you are reporting.

Please note that if the provider is operating at or near capacity and experiences patient turnover during a month, it is possible that he/she will report more than the total allowable caseload, even if the provider never had a concurrent caseload exceeding the total for which he/she is waivered. Therefore, SAMHSA will not regard these reported totals as violations unless they are consistently over the limit by, for example, 10 or more patients.

For item 10b, please enter the 2-digit month and number of patients to whom you both prescribed or dispensed covered medications and directly provided behavioral health services for each of the 12 months on which you are reporting.*

For item 10c, please enter the 2-digit month and number of patients to whom you prescribed or dispensed covered medications but who received behavioral health services[ii] from another entity through a formal established agreement for each of the 12 months on which you are reporting.* When using an electronic health record to describe the clinical reason why a provider is sending the patient to another provider for care, please use the terms "psychosocial or case management services."

For item 11, please check the box next to each element included in your diversion control plan. You should check all the boxes that apply.

For item 12, please check the boxes that reflect the circumstances under which these queries are made.

For item 13, please enter any elements in your diversion control plan that were not included in the list. For more information about diversion control plans, please refer to http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf and http://store.samhsa.gov/shin/content/SMA16-4938/SMA16-4938.pdf.

For item 14, please review the form for accuracy and completion. Sign and date the form.

Covered means drugs or combinations of drugs that are covered under 21 U.S.C. 823(g)(2)(c), such as buprenorphine.

Behavioral health services is defined as any non-pharmacological intervention carried out in a therapeutic context at an individual, family, or group level. Interventions may include structured, professionally administered interventions (e.g., cognitive behavior therapy or insight oriented psychotherapy) delivered in person, interventions delivered remotely via telemedicine s treatment outcomes, or non-professional interventions.

2. Practitioner Reporting Form

1. 1. NAME OF PRACTITIONER:

Sample Practitioner, M.D.

2. 2. State Medical License Number:

TX324wsTW

3. 3. Specialty:

Internal Medicine

4. 4. DEA License Number: (not your "X" number)

Bf2353753

5. 5. Address of Primary Service Location (Include Zip Code):

2342 Example, Blvd.
Suite 789
Sample City, LA 65498

6. 6. Telephone Number (Include Area Code)

123-321-4566

7. 7. Fax Number (Include Area Code)

321-654-4565

8. 8. Email Address (Required)

sample@example.com

9. 9a. This report covers the 12-month period beginning month. (Jan=01, Dec=12)

	01	02	03	04	05	06	07	08	09	10	11	12
Month										X		

9b. This report covers the 12-month period beginning year.

2016

9c. This report covers the 12-month period ending month. (Jan=01, Dec=12)

	01	02	03	04	05	06	07	08	09	10	11	12
Month									X			

9d. This report covers the 12-month period ending year.

2017

10. 10a. How many patients were prescribed or dispensed covered medications during each month of the preceding 12 months:

	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
Month (Jan=01, Dec=12)	10	11	12	1	2	3	4	5	6	7	8	9
# Patients	88	103	123	130	135	128	129	140	145	150	158	158

11. 10b. Indicate the number of patients who were prescribed or dispensed covered medications during each month of the preceding 12 months and also received behavioral health services, as defined in section 42 C.F.R. §8.2, from the prescribing practitioner:

	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
Month (Jan=01, Dec=12)	10	11	12	1	2	3	4	5	6	7	8	9
# Patients	66	86	89	94	94	88	104	101	100	91	121	123

12. 10c. Indicate the number of patients who were prescribed or dispensed covered medications during each month of the preceding 12 months and also were referred for behavioral health services to another entity through an established formal agreement:

	Month 01	Month 02	Month 03	Month 04	Month 05	Month 06	Month 07	Month 08	Month 09	Month 10	Month 11	Month 12
Month (Jan=01, Dec=12)	10	11	12	1	2	3	4	5	6	7	8	9
# Patients	11	34	32	27	23	33	34	34	33	33	23	24

13. 11. Check each of the elements included in the practitioner's diversion control plan:(Y/N)

	Yes	No
a. Random clinical drug testing:		X
b. Routine clinical drug testing:	X	
c. Random patient recall visits for covered medication counts:		X
d. Provision of information to patients about proper medication storage, including not sharing medication:	X	
e. Prescription drug monitoring program (PDMP) or other central repository of prescribing and dispensing record queries:	X	

If you answered "yes" to 11e, please complete item 12.

14. 12. Under your diversion control plan, under which circumstances do you check the PDMP or other central repository?

Check all that apply:

On first visit:
According to a schedule such as quarterly:

15. 13. Any other elements of the diversion control plan not already described (e.g., implants, misuse deterrent packaging such as timed single dose dispensing packaging, and disposal):

16. 14. I certify that the information presented above is true and correct to the best of my knowledge. Note: Any false, fictitious, or fraudulent statements or information presented above or misrepresentations relative therto may violate Federal laws and could subject you to prosecution, and/or monetary penalties, and or denial, revocation, or suspension of DEA registration, and/or suspension or revocation of SAMHSA's approval of the Request for Patient Limit Increase. (See 18 USC § 1001; 31 USC §§ 3801-3812; 21 USC § 824; 42 C.F.R. § 8.650.)

Signature of: Sample Practitioner, M.D.

17. Date

12/27/2017

Substance Abuse and Mental Health Services Administration

This form is intended to ensure compliance with 42 C.F.R. Part 8, Subpart F.

Privacy Act Information

Authority: Section 303 of the Controlled Substances Act of 1970 (21 USC § 823(g)(2)).

Purpose: To obtain information required to determine whether a practitioner meets the requirements

of 21 USC § 823(g)(2) and 42 C.F.R. Part 8, Subpart F. Routine Uses: Disclosures of information

from this system are made to the following categories of users for the purposes stated:

Medical specialty societies to verify practitioner qualifications.

Other federal law enforcement and regulatory agencies for law enforcement and regulatory purposes.

State and local law enforcement and regulatory agencies for law enforcement and regulatory purposes.

Persons registered under the Controlled Substance Act (PL 91-513) for the purpose of verifying the registration of customers and practitioners.

Effect: This form was created to facilitate the review of waivers under 21 USC § 823(g)(2)

and approvals of Request for Patient Limit Increase under 42 C.F.R. Part 8, Subpart F. This

does not preclude other forms of notification.

Paperwork Reduction Act Statement

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-

0234. Public reporting burden for this collection of information is estimated to average 3 hours per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 5600 Fishers Lane, Room 15E57-B, Rockville, Maryland,20857.

3. Thank You!

Thank you for completing the 2017 Mandatory Annual Report Due for all 275 Patient Waivered Practitioners. You will receive a confirmation email within the next 24 hours.

275 Annual Report Received Confirmation

Dec 27, 2017 17:22:08 Success: Delayed Email Sent to: sample@example.com