

# Submitting Notice of Intent (NOI), Second Notification for the 100- Patient Waiver Level For Nurse Practitioners and Physicians Assistants



**MEDICATION-ASSISTED  
TREATMENT (MAT)**

Go to this link: <http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php>

### System Use Notification

- You are accessing a U.S. Government information system, which includes (1) this computer, (2) this computer network, (3) all computers connected to this network, and (4) all devices and storage media attached to this network or to a computer on this network. This information system is provided for U.S. Government-authorized use only.
- Unauthorized or improper use of this system is prohibited and may result in disciplinary action, as well as civil and criminal penalties.
- Personal use of social media on this system may result in disciplinary action unless otherwise authorized.
- By using this information system, you understand and consent to the following:
  - You have no reasonable expectation of privacy regarding any communication or data transiting or stored on this information system. At any time, and for any lawful Government purpose, the government may monitor, intercept, and search and seize any communication or data transiting or stored on this information system.
  - The government may record and audit your information system usage, including usage of personal email systems to conduct HHS businesses.
  - Any communication or data transiting or stored on this information system may be disclosed or used for any lawful Government purpose.

### Submit 275-Patient Annual Reports Using This Same Interface

#### Before you begin

Before starting this application, please make sure you have

- Your DEA Number
- Your State Medical License Number
- Your Training Certificate Information (Only Required for new Waivers)

After submitting application waiver, submit your training certificate to [csatbupinfo@dsgonline.com](mailto:csatbupinfo@dsgonline.com)

Do you work for the US military, Veterans Administration, or Indian Health Service?

Yes  No

[Next](#)

For more information, contact the SAMHSA Center for Substance Abuse Treatment's (CSAT's) Buprenorphine Information Center at 866-BUP-CSAT (866-287-2728) or send an email to [infobuprenorphine@samhsa.hhs.gov](mailto:infobuprenorphine@samhsa.hhs.gov).

Select "Yes" or "No."  
Click "Next."

Look up your DEA number and address on file here: <https://apps.deadiversion.usdoj.gov/webforms/validateLogin.jsp>

## Check your waiver eligibility

Enter your information below to check your waiver eligibility and get started.

Select type.

Select your practitioner type:

MD/DO  APRN (NP/CNS/CRNA/CNM)  PA

Select state.

Licensing State:

~select

Enter ML number.

State Medical License Number:

Letters and numbers only. No spaces or dashes.

Enter DEA number.

DEA Registration Number:

Letters and numbers only. No spaces or dashes.

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Submit

If you were previously certified for a 30 waiver and want to increase your patient limit to the 100, this is the prompt you will see once you put in your correct information. Please note that, to generate this prompt, the information typed needs to be exactly what we have in our system. Call the Buprenorphine Information Center at 1.866.287.2728, if you are unsure.

## Eligible For Waiver Level 100

It appears you are eligible for waiver level 100. Click next to get started.

Next

Select your practitioner type:

- MD/DO
- APRN (NP/CNS/CRNA/CNM)
- PA

Licensing State:

Maryland ▼

State Medical License Number:

123456

DEA Registration Number:

MZ5521231

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Submit

Information that is Auto populated should not be changed. This will result in a duplicate application which will not be processed. If you need to update your information, please do so here:

<http://buprenorphine.samhsa.gov/forms/update-contact-info-login.php>

1A. NAME OF PRACTITIONER

First Name: Test Middle Name: Last Name: Test Suffix:

1B. State Health Professional License Number: 6667 License State: Maryland 1C. Professional Discipline: Addiction Psychiatry 1D. DEA Registration Number: AV7654321

Only one address should be specified. For the practitioner to dispense the narcotic drugs or combinations to be used under this notification, the primary address listed here must be the same primary address listed in the practitioner's registration under § 823(f).

2. ADDRESS OF PRIMARY LOCATION

1234 Anywhere Drive Address Line 2: City: Bethesda State: Maryland Zip Code: 20814

3. TELEPHONE NUMBER

888-888-8888 Extension (if applicable):

4. FAX NUMBER

xxx-xxx-xxxx

5. EMAIL ADDRESS

test@yahoo.com Confirm Email Address:

2A. Is this location a Federally Qualified Health Center (FQHC) as defined under Section 1861(aa)(4)(B) of the Social Security Act (42 U.S.C. 1395x)?

Yes No

1A. (Auto populated). 1B. (Auto populated). 1C. (Auto populated). 1D. (Auto populated). 2. (Auto populated). 2A. (Auto populated). 3. (Auto populated). 4. (Auto populated). 5. Your e-mail will auto populate, but you must enter it in the second time.

2A. Make a selection “yes” or “no”

6. Already preselected.

7. Check Box

**2A. Is this location a Federally Qualified Health Center (FQHC) as defined under Section 1861(aa)(4)(B) of the Social Security Act (42 U.S.C. 1395x)?**

Yes  No

**6. PURPOSE OF NOTIFICATION**

- New Notification to treat up to 30 patients
- New Notification, with the intent to immediately facilitate treatment of an individual (one) patient
- Second Notification of need and intent to treat up to 100 patients (existing 30-patient limit practitioners)
- New Notification to treat up to 100 patients\*

\*NOTE: In order to treat up to 100 patients in the first year, practitioners must provide medication-assisted treatment with covered medications (as such terms are defined under 42 C.F.R. § 8.2) in a qualified practice setting as described under 42 C.F.R. § 8.615.

**7. CERTIFICATION OF USE OF NARCOTIC DRUGS UNDER THIS NOTIFICATION**

- When providing maintenance or detoxification treatment, I certify that I will only use Schedule III, IV, or V drugs or combinations of drugs that have been approved by the Federal Drug Administration for use in maintenance or detoxification treatment and that have not been the subject of an adverse determination.

# 8. CERTIFICATION OF QUALIFYING CRITERIA

\* Select the “New Notification” that is applicable

\* Check if applicable

\* Make a selection based on State laws

\* Provide Supervisory/Collaborating Physician information as applicable to your State’s laws

## 8. CERTIFICATION OF QUALIFYING CRITERIA

NEW NOTIFICATION - I certify that I am either a nurse practitioner or physician assistant who satisfies the definition of a “qualifying other practitioner” under 21 U.S.C. § 823(g)(2)(G)(iv), as amended by the Comprehensive Addiction and Recovery Act of 2016.

NEW NOTIFICATION - I certify that I am either a clinical nurse specialist, certified registered nurse anesthetist or certified nurse midwife who satisfies the definition of a “qualifying other practitioner” under 21 U.S.C. § 823(g)(2)(G)(iv), as amended by the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, and I am aware that clinical nurse specialists, certified registered nurse anesthetists and certified nurse midwives, will be included in the definition of a “qualifying other practitioner” under 21 U.S.C. § 823(g)(2)(G)(iv) until October 1, 2023.

I certify that I am licensed to prescribe Schedule III, IV, or V medications for the treatment of pain under State law.

I certify that I am NOT required by State law to be supervised by OR work in collaboration with a qualifying physician to prescribe Schedule III, IV, or V medications.

OR

I certify that I am required by State law to be supervised by OR work in collaboration with a qualifying physician to prescribe III, IV, or V medications.

**Supervisory/Collaborating Physician Name**

**Supervisory/Collaborating Physician Phone Number**

**Supervisory/Collaborating Physician DEA Number**

# 8. CERTIFICATION OF QUALIFYING CRITERIA (Continued)

\* Check box

I certify that I have completed the required 24 hours of training for the treatment and management of opioid-dependent patients described under 21 U.S.C. § 823(g)(2)(G)(iv)(II)(aa), which covered the following topics: opioid maintenance and detoxification; appropriate clinical use of all drugs approved by the FDA for the treatment of opioid use disorder, initial and periodic patient assessments (including substance use monitoring); individualized treatment planning, overdose reversal, and relapse prevention; counseling and recovery support services; staffing roles and considerations; and diversion control. I am therefore a qualifying other practitioner. Check and provide copies of documentation (e.g., certificates of completion for the 8- and 16-hour MAT training courses) for all that apply.

**Completion of:**

\* Select Training Body where your training was completed

- American Society of Addiction Medicine (ASAM)
- American Osteopathic Association (AOA)/American Osteopathic Academy of Addiction Medicine (AOAAM)
- American Academy of Addiction Psychiatry (AAAP)
- American Medical Association (AMA)
- American Psychiatric Association (APA)
- The American Association of Nurse Practitioners (AANP)
- The American Academy of Physician Assistants (AAPA)
- SAMHSA's Providers' Clinical Support System (PCSS)
- American Nurses Credentialing Center (ANCC)
- American Psychiatric Nurses Association (APNA)

\* Provide Dates of training

**Please Provide Date(s) of Completion:**

## 8. CERTIFICATION OF QUALIFYING CRITERIA (Continued)

If you have had your 30 patient waiver over one year, please select the “SECOND NOTIFICATION FOR 100 PATIENTS” box

If you have had your 30 patient waiver LESS THAN one year, please select the “NEW NOTIFICATION...” box

- SECOND NOTIFICATION FOR 100 PATIENTS - I certify that my qualifications from my initial notification request have not changed.
- NEW NOTIFICATION TO TREAT 100 PATIENTS - I certify that I provide medication-assisted treatment with covered medications (as such terms are defined under 42 C.F.R. § 8.2) in a qualified practice setting as described under 42 C.F.R. § 8.615.

**Please upload a copy of your board certification and/or training certificate here. If you do not provide a copy of your certificate, this may result in delayed processing of your waiver. Please retain a copy of the training certificate for your records as proof of required training completion.**

Choose files To Upload

Choose Files

Upload a copy of your medical license and 24-hour training certificate(s) if you do not have a 30 patient waiver.

- 9. Check off both boxes.
- 10. Check applicable box.

#### 9. CERTIFICATION OF CAPACITY

- I certify that I have the capacity to provide patients with appropriate counseling and other appropriate ancillary services, either directly or by referral.
- I certify that I have the capacity to provide, directly or through referral, all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including for maintenance, detoxification, overdose reversal, and relapse prevention.

#### 10. CERTIFICATION OF MAXIMUM PATIENT LOAD

- I certify that I will not exceed 30 patients for maintenance or detoxification treatment at one time.
- Second Notification – I have provided treatment at the 30 patient limit for one year and need to treat up to 100 patients and I certify that I will not exceed 100 patients for maintenance or detoxification treatment at one time.
- Second Notification – I have provided treatment at the 30 patient limit for less than one year, but provide medication-assisted treatment with covered medications (as such terms are defined under 42 C.F.R. § 8.2) in a qualified practice setting as described under 42 C.F.R. § 8.615, and need to treat up to 100 patients. I certify that I will not exceed 100 patients for maintenance or detoxification treatment at one time.
- New Notification for 100 Patients – I will not exceed 100 patients for maintenance or detoxification treatment at one time.

The SAMHSA Treatment Locator Web site is publicly accessible at [http://buprenorphine.samhsa.gov/bwns\\_locator](http://buprenorphine.samhsa.gov/bwns_locator). The Locator Web site lists the names and practice contact information of physicians with DATA waivers who agree to be listed on the site. The Locator Web site is used by the treatment-seeking public and health care professionals to find physicians with DATA waivers. The Locator Web site additionally provides links to many other sources of information on substance abuse. No physician listings on the SAMHSA Treatment Locator Web site will be made without the express consent of the physician.

#### 10A. CONSENT

- I consent to the release of my name, primary practice address, and phone number to the SAMHSA Treatment Locator Web site.
- I do not consent to the release of my name, primary practice address, and phone number to the SAMHSA Treatment Locator Web site.

#### 10B. CONSENT Do you also want to be identified on the SAMHSA Treatment Locators as providing treatment with:

- |  | Yes                   | No                    |
|--|-----------------------|-----------------------|
| 1. Long-acting injectable naltrexone     | <input type="radio"/> | <input type="radio"/> |
| 2. Long-acting injectable buprenorphine  | <input type="radio"/> | <input type="radio"/> |
| 3. Long-acting implantable buprenorphine | <input type="radio"/> | <input type="radio"/> |

#### 11.

I certify that the information presented above is true and correct to the best of my knowledge. I certify that I will notify SAMHSA at the address below if any of the information contained on this form changes. Note: Any false, fictitious, or fraudulent statements or information presented above or misrepresentations relative thereto may violate Federal laws and could subject you to prosecution, and/or monetary penalties, and or denial, revocation, or suspension of DEA registration. (See 18 USC § 1001; 31 USC §§ 3801–3812; 21 USC § 824.)

Please type your name to sign this electronic form. Submission Date: 10/10/2019

Please re-enter your DEA Registration Number to verify:

Submit

Check a box indicating whether or not you consent.

Check "yes" or "no" — whichever applies to you.

Check off.

Sign.

Enter DEA number.

Hit the "submit" button.

# PLEASE NOTE THE FOLLOWING:

DATA Waiver Team Email Address: [InfoBuprenorphine@samhsa.hhs.gov](mailto:InfoBuprenorphine@samhsa.hhs.gov)

Confirmation e-mails are sent immediately after your application is submitted.

Approval Letters are e-mailed within 45 days of your complete application submission.

\*Please check your junk and spam folders if you have not already added [InfoBuprenorphine@samhsa.hhs.gov](mailto:InfoBuprenorphine@samhsa.hhs.gov) to your contacts.

Any questions or inquiries should be directed to [InfoBuprenorphine@samhsa.hhs.gov](mailto:InfoBuprenorphine@samhsa.hhs.gov) or call 1-866-287-2728.