

Opioid Treatment Program: Mobile Medication Units

Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

AATOD: Expanding the Use of Mobile Units
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May 31, 2023



SAMHSA
Substance Abuse and Mental Health
Services Administration

DPT has three main areas of focus:

- Certification and Accreditation of Opioid Treatment Programs (OTPs)
- Provider Training and Support
- Implementation of medications for substance use disorders in non-OTP settings

Background and Context

Opportunities for providing medications for opioid use disorder (MOUD) in Mobile Units:

- Servicing Rural Areas
- Servicing indigent population
- Formal agreements with Jails/Prisons
- Providing buprenorphine prescriptions
- Ability to provide the same services as an OTP, where space allows for quality patient care.

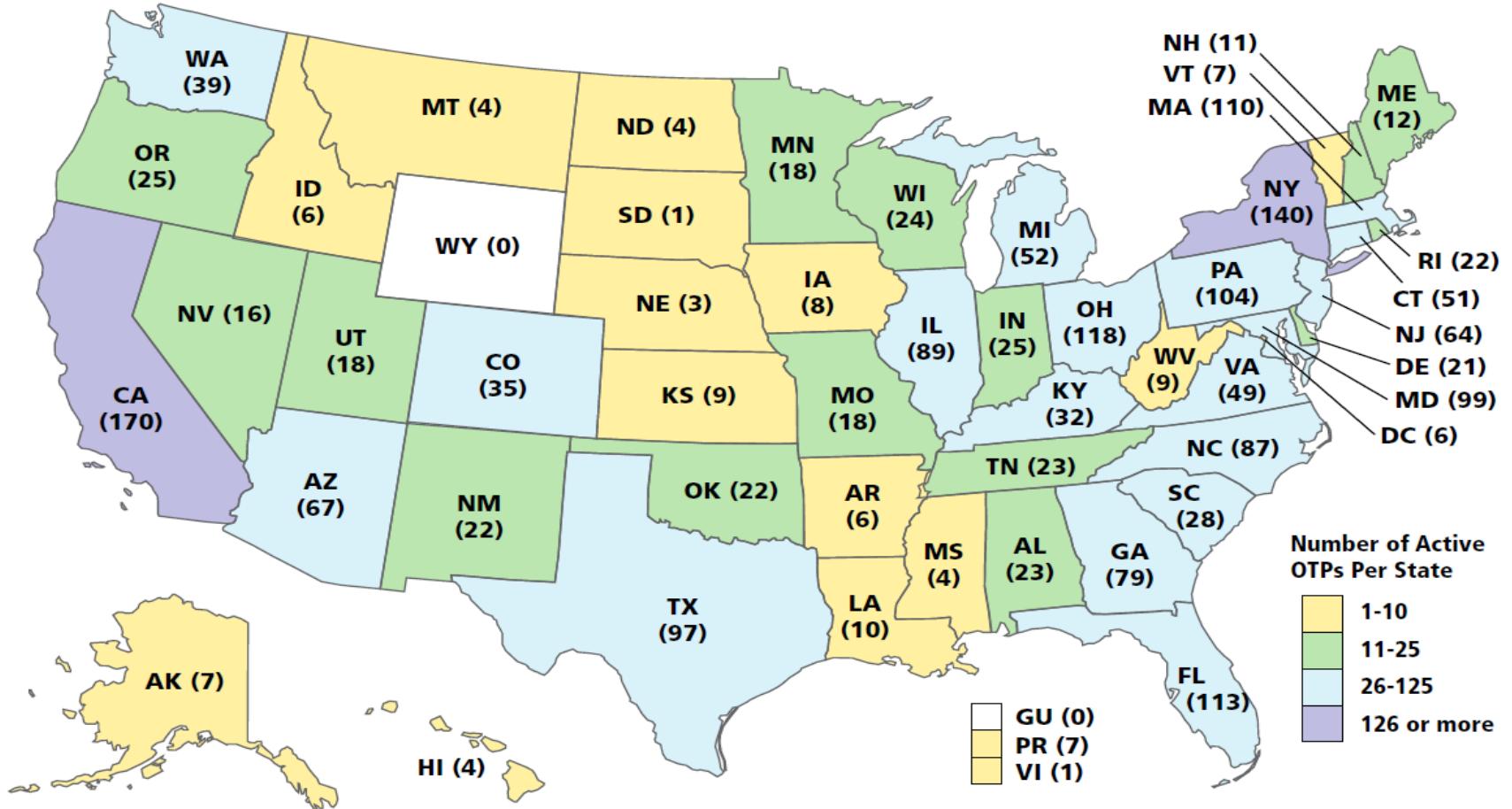
Some barriers to adding mobile units:

- State Rule Making
- Financing
- Distance/Location
- Patient Population to Support Expansion

SAMHSA Certified Opioid Treatment Programs

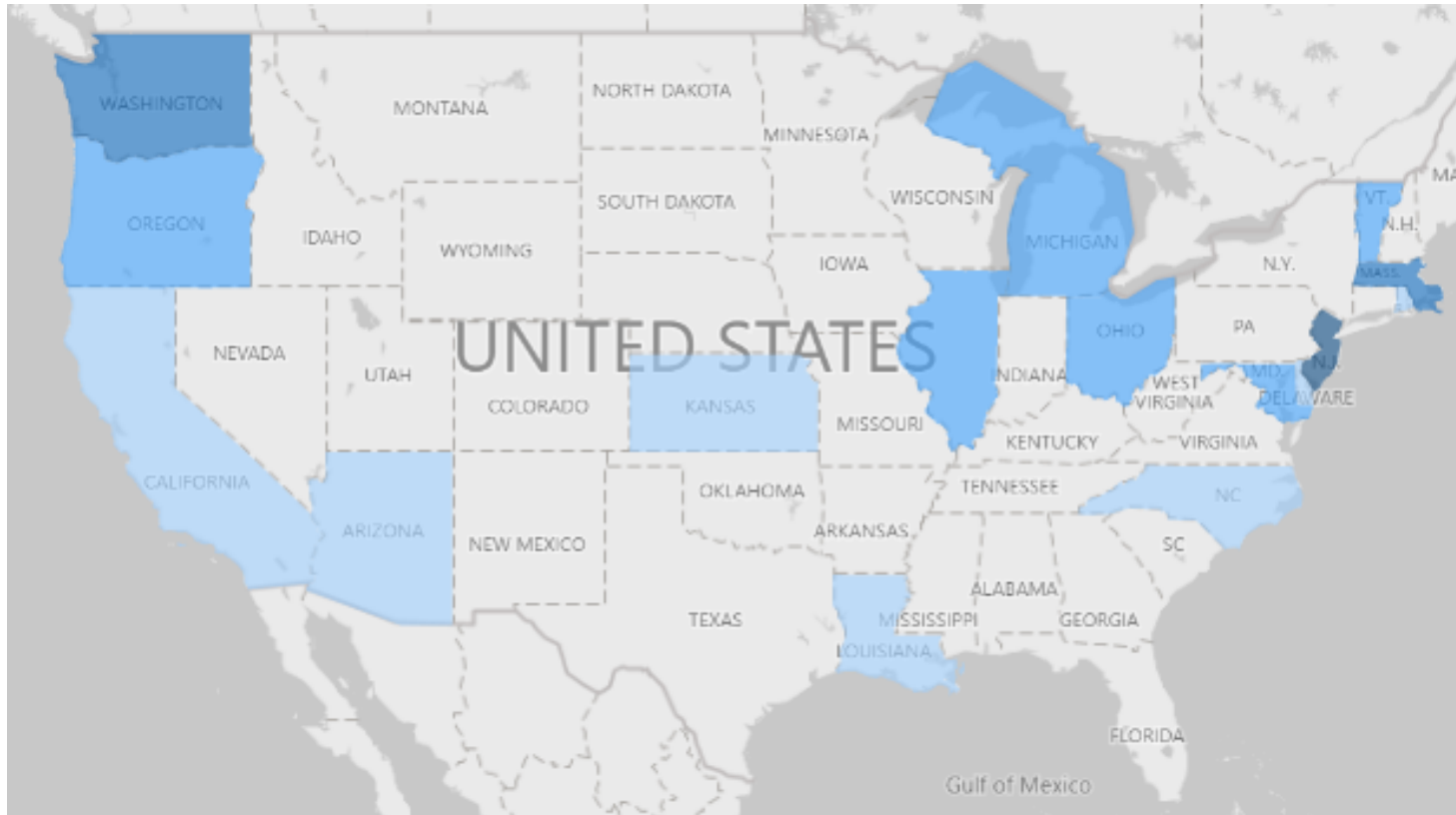
SAMHSA Certified Opioid Treatment Programs

Total=2,019



Source: SAMHSA, CSAT, OTP Database. April 2023

OTP Mobile Units Across the US



State	Mobile Units
AZ	1
CA	1
DE	1
KS	1
LA	1
NC	1
RI	1
IL	2
MD	2
MI	2
OH	2
OR	2
VT	2
MA	3
WA	3
NJ	4
PR	4
Total	33



As of 5/22/2023

OTP Mobile Unit Application Process

dpt SAMHSA/CSAT Opioid Treatment Program Extranet
CSAT's Division of Pharmacologic Therapies

Home Archived Exceptions **SMA-162s** Exemptions Manage Accounts My Account Help Logout

SMA-162: Application for Certification to Use Opioid Drugs in a Treatment Program

Hello Test Program Sponsor
Addiction Treatment Services at Johns Hopkins Bayview ABC,
MD10001M

[Submitted SMA-162s](#)
[New SMA-162](#)
[SMA-162 Instructions](#)
[Download Certificate](#)

Note: The SMA-162 form may only be submitted by the Program Sponsor. View the [instruction](#) page for the uses of the SMA-162 form and instructions on how to complete it.

DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION CENTER FOR SUBSTANCE ABUSE TREATMENT	Form Approved: OMB Number 0930-0206 Expiration Date: 12/31/2021 OMB Statement
Application for Certification to Use Opioid Drugs in a Treatment Program Under 42 CFR § 8.11	DATE OF SUBMISSION: 8/10/2021

Note: This form is required by 42 CFR 8.11 pursuant to Sec. 303, Controlled Substances Act (21 USC § 823) and the Drug Abuse Prevention and Control Act of 1970 (42 USC § 275(a)). Failure to report may result in a recommendation for the suspension or revocation of the opioid treatment program registration.

SMA-162: Mobile Unit

- The first section contains the purpose of the form
- You must choose 'Medication Unit' in order to populate the correct information required for this request
- Question 1 is pre-filled with OTP information and is not editable

Note: The SMA-162 form may only be submitted by the Program Sponsor. View the [Instruction](#) page for the uses of the SMA-162 form and instructions on how to complete it.

DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION CENTER FOR SUBSTANCE ABUSE TREATMENT	Form Approved: OMB Number 0930-0206 Expiration Date: 11/30/2024 OMB Statement
Application for Certification to Use Opioid Drugs in a Treatment Program Under 42 CFR § 8.11	DATE OF SUBMISSION: 5/25/2023
Note: This form is required by 42 CFR 8.11 pursuant to Sec. 303, Controlled Substances Act (21 USC § 823) and the Drug Abuse Prevention and Control Act of 1970 (42 USC § 275(a)). Failure to report may result in a recommendation for the suspension or revocation of the opioid treatment program registration.	
* PURPOSE OF APPLICATION (check one) <input type="radio"/> Provisional Certification <input type="radio"/> Renewal/Re-certification <input type="radio"/> New Sponsor <input type="radio"/> New Medical Director <input type="radio"/> Relocation <input checked="" type="radio"/> Medication Unit	
* 1a. NAME OF PROGRAM (Name of primary dispensing location):	Addiction Treatment Services at Johns Hopkins Bayview ABC-S
b. DOING BUSINESS AS:	DBA is Here
c. OPIOID TREATMENT PROGRAM NUMBER (OTP NUMBER):	MD10001M (same as FDA ID, e.g. AL-10001-M)
d. DEA REGISTRATION NUMBER:	PS0138164-RL
e. I-SATS ID: (e.g., AL100002)	
f. National Provider Identification Number: (e.g., 1234567890)	

SMA-162: Mobile Unit

- Questions 2-11 are also pre-filled with information stored in the OTP Extranet about the OTP
- Note, because the purpose is medication unit, you cannot change any information about the Program Sponsor or Medical Director
- You must submit a separate SMA-162 for change requests

<p>2. ADDRESS OF PRIMARY DISPENSING LOCATION (If new address make sure to check the "Relocation")</p> <p>* Address 1: <input type="text" value="Test 0301-RL"/></p> <p>Address 2: <input type="text"/></p> <p>* City: <input type="text" value="Glen Burnie"/></p> <p>* State: <input type="text" value="MD"/></p> <p>* Zip: <input type="text" value="21209"/></p>	<p>3. PROGRAM TELEPHONE NUMBER <input type="text" value="(343) 343-4333"/></p> <p>4. PROGRAM E-MAIL ADDRESS <input type="text" value="454878@jbsinternational.com"/></p>
<p>5. NAME AND ADDRESS OF PROGRAM SPONSOR (If new Program Sponsor make sure to check the "New Program Sponsor")</p> <p>* First Name: <input type="text" value="Test"/></p> <p>* Last Name: <input type="text" value="ProgramSponsor"/> <small>(Must be the name of an individual, not a company or organization)</small></p> <p>Degree: <input type="text"/></p> <p><input type="checkbox"/> Same address as primary dispensing location</p> <p>* Address 1: <input type="text" value="123 Test RD"/></p> <p>Address 2: <input type="text"/></p> <p>* City: <input type="text" value="Test-NM"/></p> <p>* State: <input type="text" value="DC"/></p> <p>* Zip: <input type="text" value="09091"/></p>	<p>6. PROGRAM SPONSOR TELEPHONE NUMBER <input type="text" value="(555) 555-5555"/></p> <p>7. PROGRAM SPONSOR E-MAIL ADDRESS <input type="text" value="test_programsponsor@jbsinternal"/></p> <p><i>Note: A confirmation email will be sent to this address. The Program Sponsor will need to respond to that email to electronically sign this SMA-162 and complete the submission process.</i></p>
<p>8. NAME OF MEDICAL DIRECTOR - (and Address if different than Dispensing Location, above). If new Medical Director make sure to check the "New Medical Director"</p> <p>* First Name: <input type="text" value="John"/></p> <p>* Last Name: <input type="text" value="Doe"/></p> <p>Degree: <input type="text" value="MD"/></p> <p><input type="checkbox"/> Same address as primary dispensing location</p> <p>* Address 1: <input type="text" value="5515"/></p> <p>Address 2: <input type="text" value="Security Lane"/></p> <p>* City: <input type="text" value="Anchorage"/></p> <p>* State: <input type="text" value="AK"/></p> <p>* Zip: <input type="text" value="99501"/></p>	<p>9. MEDICAL DIRECTOR TELEPHONE NUMBER <input type="text" value="123-123-1234"/></p> <p>10. MEDICAL DIRECTOR DEA NUMBER <input type="text" value="FM1144233"/></p> <p>11. MEDICAL DIRECTOR E-MAIL ADDRESS <input type="text" value="test_facility@jbsinternational.com"/></p> <p><i>The Medical Director's email address must be one to which only the Medical Director has access. It must not be the same as the program's email address or that of any other program personnel.</i></p>

SMA-162: Mobile Unit

- The next section is where you complete the information about the Medication Unit
- **You must choose the purpose of the medication unit**
- Then you fill in all of the relevant information about the medication unit, and check 'Mobile Van' if applicable
- State is not editable, as it must be located in the same state as the primary OTP

Enter information for the new Medication Unit

* Purpose of medication unit (check one)

I affirm that that the medication unit is limited to administering and dispensing the narcotic treatment drug and collecting samples for drug testing or analysis.

I affirm that that the medication unit is administering and dispensing the narcotic treatment drug, collecting samples for drug testing or analysis, and other expanded services listed in this letter ([Letter to OTP Directors, SOTAs and State Directors on Mobile Component \(samhsa.gov\)](#))

* Site Name:

DEA Number:

Mobile Van:

* Address Line 1:

Address Line 2:

* City:

* State:

* Zip: (e.g., 99999-9999)

Phone: (e.g., 999-999-9999)

Fax: (e.g., 999-999-9999)

Email ID:

SMA-162: Mobile Unit

- The last section on the first page requires that you enter at least one treatment type and the number of patients receiving that type of treatment in question 13
- Question 14 is also pre-filled with current information about your OTP
- When you are done with this page, please click 'Next'

* 13. NUMBER OF PATIENTS IN TREATMENT ON DATE OF SUBMISSION:		
Treatment Type	Number of Patients	
<input checked="" type="checkbox"/> Methadone	4	
<input checked="" type="checkbox"/> Buprenorphine	100	
<input checked="" type="checkbox"/> Naltrexone	50	
<input type="checkbox"/> Other (Specify)	4	
Xiesty Z		
* 14a. PROGRAM STATUS Non-profit		
* 14b. PROGRAM FUNDING SOURCES (Check each appropriate agency and attach the address of each, if applicable.)		
<input type="checkbox"/> SAMHSA Grant	<input checked="" type="checkbox"/> Private Charities	<input type="checkbox"/> Department Of Veterans Affairs
<input checked="" type="checkbox"/> Patient Payment	<input checked="" type="checkbox"/> State Government	<input type="checkbox"/> County Government
<input checked="" type="checkbox"/> Indian Health Service	<input checked="" type="checkbox"/> Private Health Insurance	<input checked="" type="checkbox"/> Other (Specify): RL
15. Comments 		
<p><small>*The preferred method for submitting this form to CSAT/DPT for a provisional certification is on the MAT Web site which contains complete instructions for preparing and submitting your request. http://opod.samhsa.gov/sma162. Submission of the SMA-162 for provisional certification and other purposes named in item #12 above are described here. http://www.samhsa.gov/medication-assisted-treatment/opod-treatment-otp-otps.aspx. It is highly encouraged that submission take place in this capacity. If you are unable to submit online, the form may be e-mailed as an attachment to your compliance officer whose contact information can be found at http://www.samhsa.gov/medication-assisted-treatment/opod-treatment-otp-otps.aspx, or sent by traditional mail (include three copies of all attachments) to the mailing address below. Additional information can be found on the MAT webpage. http://www.samhsa.gov/medication-assisted-treatment.</small></p> <p style="text-align: center;">Center for Substance Abuse Treatment Division of Pharmacologic Therapies Substance Abuse and Mental Health Services Administration Attention: OTP Certification Program 5600 Fishers Lane, Rockville, MD 20857</p>		
<p>I certify that the information being submitted 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 submitted changes. Note: Any false, fictitious, or fraudulent statements or information presented in this submission 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 U.S.C. Section 1001; 21 U.S.C. Sections 801-812; 21 U.S.C. Section 824.)</p>		
Paperwork Reduction Act Statement <small>Public reporting burden for this collection of information is estimated to average between 6 minutes and 1 hour per response, 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, Paperwork Reduction Project (0930-0208), 5600 Fishers Lane, Rockville, MD 20857. 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 0930-0208. Back to top</small>		
FORM SMA-162 (revised 2018)		<input type="button" value="Back"/> <input type="button" value="Next"/>

SMA-162: Mobile Unit

- This page lists required documentation for your medication unit and tabs to attach them.

Based on the purpose(s) you have selected on the SMA-162 form, SAMHSA requires the additional documents listed below to complete the processing of your request.

Files may be attached in the following formats: .pdf, .txt, .doc, .tiff. Files may not be larger than 4 MB. Please keep file names to no longer than 15 characters. Long file names may not allow SAMHSA to download the file properly, even if you can upload it.

Checklist Item	Attached File	Attach File
A description of how the medication unit receives the medication supply from the primary facility.		<input type="button" value="Choose File"/> <input type="button" value="No file chosen"/> Upload File Cancel
An affirmative statement that the sponsor agrees to retain responsibility for patient care.		<input type="button" value="Choose File"/> <input type="button" value="No file chosen"/> Upload File Cancel
A detailed labeled floor diagram of the medication unit.		<input type="button" value="Choose File"/> <input type="button" value="No file chosen"/> Upload File Cancel
A written description of the facilities to be used as a medication unit.		<input type="button" value="Choose File"/> <input type="button" value="No file chosen"/> Upload File Cancel
The total number of patients to be served by the primary facility and medication unit.		<input type="button" value="Choose File"/> <input type="button" value="No file chosen"/> Upload File Cancel
The total number of patients that will be served only at the medication unit.		<input type="button" value="Choose File"/> <input type="button" value="No file chosen"/> Upload File Cancel
A justification for the need to establish a medication unit.		<input type="button" value="Choose File"/> <input type="button" value="No file chosen"/> Upload File Cancel
The name and address of any medication unit or units currently attached to the primary facility.		<input type="button" value="Choose File"/> <input type="button" value="No file chosen"/> Upload File Cancel
Upload optional additional file.		<input type="button" value="Choose File"/> <input type="button" value="No file chosen"/> Upload File Cancel

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[SUBMIT](#)

Medication/Mobile Unit Checklist

- A description of how the medication unit will receive the medication supply from the primary facility.
- An affirmative statement that the sponsor agrees to retain responsibility for patient care.
- A detailed labeled floor diagram of the medication unit.
- A written description of the facilities to be used as a medication unit.
- Total number of patients to be served by the primary facility and mobile unit (combined).
- Total number of patients that will be served only at the mobile unit.
- A justification for establishing a medication unit.

Mobile Unit Application Concurrences

1. The request must be approved by:

- SAMHSA
- State opioid treatment authority (SOTA)
- Drug Enforcement Administration (DEA) Regional Office

2. SAMHSA-approved Accrediting Body

- The accreditation of the primary OTP will extend to the mobile unit.
- The mobile unit will be reviewed during the next scheduled survey cycle.

Help is available!

For problems in accessing your program's account, call the OTP Extranet Helpdesk at: 1-866-348-5741 or email: OTP-Help@jbsinternational.com

For any other guidance or support please call your OTP Compliance Officer at (240) 276-2700 or email: DPT@samhsa.hhs.gov.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD)