

~VIVITROL~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of Vivitrol (naltrexone for IM extended release suspension). These criteria are based on concerns about safety. In order for beneficiaries to receive coverage for Vivitrol, it will be necessary for the prescriber to complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via Fax: 1-866-767-2649

Prescribing physician:

Name: _____

Phone #: _____

Fax #: _____

Address: _____

Contact Person at Office: _____

Beneficiary:

Name: _____

Medicaid ID #: _____

Date of Birth: _____ Sex: _____

Diagnosis: _____

Administering physician:

Name: _____

Address: _____

Pharmacy (required): _____ **Phone:** _____ **&/or FAX:** _____

QUALIFICATIONS

MDs	Prescribers must secure direct delivery of Vivitrol from the pharmacy to the physician's office. Pharmacies may not dispense Vivitrol directly to the patient. Vivitrol may not be billed through the Medical Benefit as a J-Code J2315.
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PROCESS

► Please answer the following questions:

Patient diagnosis/indication for use?	<input type="checkbox"/> Alcohol dependence <input type="checkbox"/> Prevention of relapse to opioid dependency
Has the patient been opiate free for > 7 – 10 days	<input type="checkbox"/> Yes <input type="checkbox"/> No
For alcohol dependence: (1) Has the patient tried any of the following? Please document below. oral naltrexone: <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy acamprosate: <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy disulfiram: <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No
(2) Has patient had a recent hospital admission for alcohol detoxification?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: ____/____/____
For prevention of relapse to opioid dependency (1) Has the patient failed buprenorphine therapy? (2) Is the patient not a candidate for buprenorphine therapy? (3) Patient requires injectable therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments and additional patient history:	

Prescriber Signature: _____ **Date of request:** _____