



Department of Vermont Health Access  
 312 Hurricane Lane, Suite 201  
 Williston, Vermont 05495

VIVITROL.4  
 FORM#27  
 R: 12.15

Agency of Human Services

~VIVITROL~

**Prior Authorization Request Form**

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 Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

**Submit request via: Fax: 1-844-679-5366**

Prescribing physician:

Beneficiary:

Name: \_\_\_\_\_  
 Physician NPI: \_\_\_\_\_  
 Phone#: \_\_\_\_\_  
 Fax#: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Contact Person at Office: \_\_\_\_\_

Name: \_\_\_\_\_  
 Medicaid ID#: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Pharmacy Name \_\_\_\_\_  
 Pharmacy NPI: \_\_\_\_\_  
 Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

**Administering Physician (Name):** \_\_\_\_\_ **Address:** \_\_\_\_\_

**PROCESS**

Patient diagnosis/indication for use?	<input type="checkbox"/> Alcohol dependence	<input type="checkbox"/> Prevention of relapse to opioid dependency
<b>For alcohol dependence:</b> <b>(1)</b> Has the patient tried any of the following? Please document below. oral naltrexone: side-effect non-response allergy acamprosate: side-effect non-response allergy disulfiram: side-effect non-response allergy <b>(2)</b> Has patient had a recent hospital admission for alcohol detoxification?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: ___/___/___
<b>For prevention of relapse to opioid dependency</b> <b>(1)</b> Has the patient had a trial of oral naltrexone? If yes, for how many days? _____ <b>(2)</b> Has the patient been opiate free for > 7 – 10 days? <b>(3)</b> Check this box if the patient received first dose in Corrections or Treatment HUB, and is continuing therapy on Vivitrol <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments and additional patient history:		

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

**Prescriber Signature:** \_\_\_\_\_ **Date of request:** \_\_\_\_\_

