Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

VIVITROL

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare help desk at 1-844-679-5363.

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

Prescribing physician:

Name: ________________________________
Physician NPI: __________________________
Specialty: _____________________________
Phone#: _______________________________
Fax#: _________________________________
Address: ______________________________
Contact Person at Office: _________________

Beneficiary:

Name: ____
Medicaid ID#: ______________________________________
Date of Birth: _______________________ Sex: ___________
Pharmacy Name____________________________________
Pharmacy NPI: ______________________________________
Pharmacy Phone: ____________Pharmacy Fax: ___________

Administering Physician (Name): ____________________________Address: ____________________________________

Patient diagnosis/indication for use? ☐Alcohol dependence ☐ Prevention of relapse to opioid dependency

For alcohol dependence:

(1) Has the patient had a trial of oral naltrexone to test for tolerability? ☐ Yes ☐ No

(2) Is the patient actively drinking alcohol? ☐ Yes ☐ No

For prevention of relapse to opioid dependency:

(1) Has the patient had a trial of oral naltrexone to test for tolerability? ☐ Yes ☐ No

(2) Has the patient been opiate free for > 7 – 10 days? ☐ Yes ☐ No

(3) Has the patient received the first dose in corrections or treatment HUB and is continuing therapy on Vivitrol? ☐ Yes ☐ 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:**_____________