

VIVITROL (naltrexone extended-release injection) PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for Vivitrol, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Vivitrol (accessible at: <http://www.dhs.state.pa.us/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
Facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: <input type="checkbox"/> Vivitrol 380 mg IM injection	Directions:	Qty:	Refills:
Diagnosis:		Diagnosis code (required):	
Provider Type: <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Licensed Drug & Alcohol (D&A) <input type="checkbox"/> Other (specify): _____			

All requests:

1. Does the Recipient have any of the following contraindications to Vivitrol? Check all that apply.		<input type="checkbox"/> Yes <i>Submit</i>
<input type="checkbox"/> Current physiologic opioid dependence <input type="checkbox"/> Current use of licit or illicit opioids <input type="checkbox"/> Positive urine drug screen (UDS) for opioids		<input type="checkbox"/> No <i>documentation</i>
2. Was Vivitrol initiated prior to release from a correctional facility or inpatient D&A program?		<input type="checkbox"/> Yes – <i>correctional facility (jail/prison)</i> <input type="checkbox"/> Yes – <i>inpatient D&A program</i> <input type="checkbox"/> No

****Continue to INITIAL or RENEWAL section****

Initial requests:

1. Has the Recipient been diagnosed with opioid use disorder or alcohol use disorder as documented by a history consistent with current Diagnostic & Statistical Manual (DSM) criteria?		<i>Submit medical record documentation that all criteria have been met</i>
<input type="checkbox"/> Yes, opioid use disorder <input type="checkbox"/> Yes, alcohol use disorder <input type="checkbox"/> No		
2. Does the Recipient have evidence of oral naltrexone tolerability (ie, has the Recipient taken a "test dose" of oral naltrexone)?		<input type="checkbox"/> Yes – <i>submit documentation of medication admin. record, copy of prescription, or chart notes</i> <input type="checkbox"/> No
3. Check all that apply to the Recipient and <i>submit supporting documentation (such as lab results, chart notes, etc.)</i> .		
<input type="checkbox"/> Recent lab work that includes liver function tests <input type="checkbox"/> Has an initial or scheduled evaluation by a licensed D&A provider or Single County Authority (SCA) to determine level of care	<input type="checkbox"/> Participation in, or referral to, a licensed D&A program, as recommended in the initial evaluation <input type="checkbox"/> Has not used or taken opioids for at least 7-10 days prior to initial dose	<input type="checkbox"/> Had a mental health screening performed <input type="checkbox"/> If diagnosed with depression, is receiving (or has been referred for) treatment

Renewal requests:

1. Record date of initial Vivitrol dose: _____ and date of most recent Vivitrol dose: _____	
2. Check all that apply to the Recipient and <i>submit supporting documentation (such as lab results, chart notes, etc.)</i> .	
<input type="checkbox"/> Lab work from the past 6-12 months that includes liver function tests <input type="checkbox"/> If diagnosed with depression, continues to receive treatment for that condition <input type="checkbox"/> Participation in, or successful completion of, a licensed D&A program	<input type="checkbox"/> Upon successful completion of the licensed D&A program, participation in a substance abuse or behavioral health counseling/treatment program or an addictions recovery program
3. <i>For a diagnosis of opioid use disorder:</i> Has the Recipient recently tested negative on a UDS for illicit AND licit drugs of abuse, including oxycodone and fentanyl?	<input type="checkbox"/> Yes – <i>submit documentation of test date and results</i> <input type="checkbox"/> No
4. <i>For a diagnosis of alcohol use disorder:</i> Has the Recipient been abstinent from alcohol since beginning treatment?	<input type="checkbox"/> Yes – <i>submit medical record documentation of history of abstinence AND date and results of alcohol testing</i> <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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