Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

VIVITROL
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Vivitrol (Naltrexone)	380mg Powder Vial (IV)			

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis:	Date Diagnosed:

Does the member have acute hepatitis or liver failure?	□ Yes	□ No
Has the member previously tried and tolerated oral naltrexone?	□ Yes	□ No
Is the member currently in acute opioid withdrawal?	□ Yes	□ No
Is the member currently taking any opioids?	□ Yes	□ No

If yes, please provide name(s):_____

Has the member been opioid-free for a minimum of 7 to 10 days before starting naltrexone? □ Yes □ No

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

Please submit the following:

- ✓ **Please submit documentation of active participation in a comprehensive management program which provides psychosocial support, including:**
  - Documentation of an initial evaluation or scheduled appointment with a licensed Drug & Alcohol Provider to determine the recommended level of care
  - Documentation of referral to or enrollment in formal behavioral health counseling and/or substance abuse counseling that is consistent with the level of care recommended at the initial evaluation. Initial treatment must be performed by a licensed Drug & Alcohol Provider or a behavioral health provider.
- ✓ **Please submit documentation of a recent urine drug screen, including date of test. Testing should include opioids.**

☐ **Documentation enclosed** ☐ **Documentation unavailable**

Is this request for reauthorization? ☐ **Yes** ☐ **No**

If yes, please include the following documentation:

- ✓ Documentation showing member's disease has stabilized
- ✓ Documentation showing the member is not on opioids
- ✓ Documentation of active participation in at least monthly formal behavioral health counseling, substance abuse counseling, or an addiction recovery program.
- ✓ Documentation of a recent urine drug screen, including date of test (for diagnosis of opioid dependence). Testing should include opioids.

☐ **Documentation enclosed** ☐ **Documentation unavailable**

Please provide any additional information which should be considered in the space below: