

Network Health

Prior Authorization Request Vivitrol (naltrexone)

Medication Request Form (MRF)

FAX TO: (877) 501-1059

c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department

10680 Treena Street, Suite 500, San Diego, CA 92131 - Phone: 1-800-788-2949

Vivitrol (naltrexone extended release injection)

Instructions:

This form is to be used by participating providers to obtain coverage for the drugs listed above, which require prior authorization. Please complete this form and fax it to MedImpact Healthcare Systems, Inc. at (877) 501-1059. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

***** ONLY COMPLETED FORMS CAN BE PROCESSED *****

Member/Provider Information:

Member's Name:	Prescriber/Provider's Name:
Member's Network HealthID #:	Prescriber/Provider's Specialty:
Member's DOB (mm-dd-yy):	DEA #(Required): _____ NPI #: _____
Pharmacy used by Member:	Prescriber/Provider's Telephone Number/ Contact Name:
Pharmacy (Area Code) Telephone Number:	Prescriber/Provider's (Area Code) Fax Number:

MEDICATION REQUEST INFORMATION

Please check all that apply:

- Vivitrol 380mg intramuscularly every 4 weeks (28 days) Vivitrol 380mg intramuscularly every 4 weeks (30 days)

REQUIRED CLINICAL INFORMATION FOR INITIAL REQUESTS

Please check all that apply:

- Diagnosis : 303.9 Chronic Alcoholism/Unspecified Alcohol Dependence 304.0 Opioid Type Dependence
 Other (please list): _____

- Is the patient currently abstaining from opioids? Yes No
- Has an allergy to naltrexone been ruled out for this patient? Yes No
- Has the patient been stable on Vivitrol for 3 months or longer prior to the request? Yes No
- Has the patient tried and failed a course of therapy of at least 30 days duration with oral naltrexone? Yes No

If yes to treatment failure with a 30 day course of oral naltrexone, please provide date(s) of treatment failure and the types of management strategies attempted to alleviate the concerns of compliance, side effects, or unsteady blood levels: _____

If no, please provide clinical justification as to why oral naltrexone cannot be used: _____

- Is the patient currently receiving psychosocial support? Yes No

If no, please provide clinical justification why: _____

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REQUIRED CLINICAL INFORMATION FOR RENEWAL REQUESTS

Please check all that apply:

Alcohol and Opioid Dependency

- Is the patient currently abstaining from opioids? Yes No
- Is the patient currently receiving psychosocial support? Yes No

If no, please provide clinical justification why: _____

Alcohol Dependency (only)

- Is the patient currently abstaining from alcohol? Yes No

If no, has the patient had a significant decrease in the amount of alcohol consumption or medically related services such as ER visits or detox facility admissions? Yes No

If no, what is the clinical justification to continue Vivitrol use in this patient? _____

Request for expedited review (72 hours): By checking this box, I certify that applying the standard review time frame may seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

SIGNATURE

I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Prescriber's signature (STAMP NOT ACCEPTED)

Date

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Contacted:
Provider:
Pharmacy:
Patient:

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #