AmeriHealth Administrators

Today's date: _____

Intended date of injection: _____

Prior Authorization Form – Vivitrol®

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Check one: ☐ New start ☐ Continued treatment

Patient information (please print)	**Physician information (please print)**	
Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of birth	Fax #	NPI

This drug will be delivered to the requesting physician.

**** A copy of the prescription must accompany the medication request for delivery.****

1) Indication and ICD-10: alcohol dependence _____

Indication and ICD-10: opioid dependence _____

2) Patient medical information (the questions below pertain to all patients with opioid and alcohol dependence)

a. If the patient has opioid/alcohol dependence, has the patient successfully completed an opioid/alcohol detoxification program? ☐ Yes ☐ No

b. Is the patient currently participating in a comprehensive treatment program that includes psychosocial support? ☐ Yes ☐ No

c. Is the patient residing in an inpatient facility? ☐ Yes ☐ No

d. If the patient is residing in an inpatient facility, does the facility allow drug testing? ☐ Yes ☐ No

e. Has the patient abstained from alcohol prior to administration of naltrexone (Vivitrol®)? ☐ Yes ☐ No

f. Has the patient abstained from opioids at least 7-10 days prior to administration of naltrexone (Vivitrol®)? ☐ Yes ☐ No

3) Prescription information

Quantity_____ refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Please fax this completed form to 215-761-9580.

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P.O. Box 21545 | Eagan, MN 55121