

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

VIVITROL (naltrexone)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA for Treatment of Alcohol Abuse:

- Diagnosis of alcohol abuse.
- Negative urine screen for opioids or passed naloxone challenge.
- **No concomitant treatment with Subuxone or Subutex.**
- Description of the psychosocial support to be received by patient, as indicated by chart notes or a brief letter of medical necessity.

CRITERIA for Prevention of Relapse to Opioid Dependence:

- Diagnosis of opioid dependence.
- Description of opioid detoxification measures.
- **No concomitant treatment with Subuxone or Subutex.**
- Description of the psychosocial support to be received by patient, as indicated by chart notes or a brief letter of medical necessity.

INFORMATION:

- To be given by substance abuse treatment providers. Provider will bill with J-code J2315, NDC 65757-300-01, and PA number.
- This drug is not available to patients with Primary Care Network coverage (PCN, or yellow card).

AUTHORIZATION for both indications:

Initial authorization is for 6 months.

RE-AUTHORIZATION for both indications:

Updated letter of medical necessity

08/11/11

<http://health.utah.gov/medicaid/pharmacy>