WellCare
Beyond Healthcare. A Better You.

Vivitrol® Prior Authorization Request Form

Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-855-620-1868

Member Information			Provider Information		
Member Name:			Provider Name:		
Member ID:			NPI#:	Specialty	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information		
Medication Name:	Strength:	Dosage Form:
☐ Check if requesting **brand**	Directions for Use:	
☐ Check if requesting for **continuation of therapy**		

Required Clinical Information

****please submit all required clinical notes/lab reports in reference to this request****

Select the diagnosis below:

☐ Alcohol dependence
☐ Opioid dependence
☐ Other diagnosis: _____ ICD-10 Code(s):_____

Clinical Information:

Is the patient 18 years of age or older? ☐ **Yes** ☐ **No**
Is the patient a member of a court ordered treatment program with Vivitrol? ☐ **Yes** ☐ **No**
Alcohol dependence: ☐ **N/A**
Has the patient tried and failed oral naltrexone? ☐ **Yes** ☐ **No**
Is the patient actively consuming alcohol at the time of treatment initiation? ☐ **Yes** ☐ **No**
Opioid dependence: ☐ **N/A**
Has the patient tried and failed oral buprenorphine/naloxone (e.g. Zubsolv)? ☐ **Yes** ☐ **No**
Is there documentation the patient has been opioid free for at least 7 days prior to treatment initiation (e.g. recent urine drug screen, naloxone challenge test)? ☐ **Yes** ☐ **No**

Does the patient have adequate liver function that is within normal limits (WNL)? ☐ **Yes** ☐ **No**
Is there confirmation the patient is currently receiving appropriate counseling or actively participating in a recognized support groups (e.g. Alcoholics Anonymous, Narcotics Anonymous)? ☐ **Yes** ☐ **No**
Will Vivitrol be prepared and administered by a healthcare provider? ☐ **Yes** ☐ **No**
Will Vivitrol be dispensed in a physician's office (buy and bill), from a specialty pharmacy, or a non-specialty pharmacy associated with an addiction treatment center? ☐ **Yes** ☐ **No**

Reauthorization:

Opioid dependence: Has a recent random urine drug screen been submitted? ☐ **N/A** ☐ **Yes** ☐ **No**
Has the patient remained compliant with treatment? ☐ **Yes** ☐ **No**
Is this patient participating in counseling or support programs? ☐ **Yes** ☐ **No**

By signing below, you attest that all statements on this form are true to the best of your knowledge

Prescribers Signature:_____ Date:_____

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