Vivitrol Prior Authorization Form
Incomplete forms will not be reviewed

Maryland Medicaid
Office of Pharmacy Services
Fax: (866) 440-9345
Phone: (800) 932-3918

Date (mm/dd/yyyy): _____

Patient Information

Name: _____ DOB (mm/dd/yyyy): _____

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Contact Person: _____ Phone: _____ Fax: _____

Prescription Information

❑ Initial PA Request ❑ Renewal Request

Diagnosis: ❑ Alcohol use disorder (AUD) ❑ Opioid use disorder (OUD)

Medication: Vivitrol Strength: _____ Quantity: _____ Refills: _____

Directions for Use: _____

I attest that:

❑ Opioid-dependent and opioid-using patients, including those being treated for alcohol dependence, is opioid-free for a minimum of 7 – 10 days before starting Vivitrol treatment (required for AUD and OUD)

❑ Patient is abstinent from alcohol (required for AUD only)

❑ The benefits of the treatment outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge

❑ The MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original.

Prescriber's Signature: _____ Date (mm/dd/yyyy): _____