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

Vivitrol
Prior Authorization Form

Maryland
DEPARTMENT OF HEALTH

Patient's Information: **Date:** _____

Name: _____ DOB: _____

Participant's Maryland Medicaid Number: _____

Prescriber's Information:

Name: _____NPI #: _____

Phone #: _____ Fax #: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

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

Directions for Use: _____

Vivitrol Criteria

Please indicate diagnosis: ☐ **Opioid use disorder OR** ☐ **Alcohol use disorder**

☐ Negative urine test results for opioids **OR** Provider to document that the patient has passed a naloxone challenge test in the past 7 days

☐ Attest the patient is abstinent from alcohol (Required for alcohol use disorder only)

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber's Signature_____ **Date**_____

Fax this completed form to 866-440-9345, once all the required information has been provided. **Incomplete forms will not be reviewed**.

https://store.samhsa.gov/shin/content/SMA14-4892R/SMA14-4892R.pdf https://www.vivitrol.com/content/pdfs/prescribing-information.pdf

Internal Use only- Information below is to be completed by the PA pharmacist

For Vivitrol Criteria ☐ No opioid claim in the past 7 days ☐ Approved ☐ Denied

March 2020