



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 215-784-0672.