UPMC HEALTH PLAN

VIVITROL
Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES **PHONE 800-979-UPMC (8762)** **FAX 412-454-7722**

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment. Incomplete responses may delay this request.

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ☐**Brand** ☐**Generic**	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐**New medication** ☐**Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	☐**Yes** ☐**No**
Diagnosis:		**Date of diagnosis:**	

Please indicate place of infusion:
☐ Physician's office
☐ Hospital/facility
☐ Patient home

Please provide facility/provider name and address:

Please indicate how drug will be billed:
☐ **Billed directly by the provider via JCODE.**
Provide JCODE:_____
☐ **Billed by a pharmacy and delivered to the provider**
☐ **Billed by a pharmacy and delivered to the patient**

Please complete the following for ALL requests:

Does the member have acute hepatitis or liver failure?	☐**Yes** ☐**No**
Has the member previously tried and tolerated oral naltrexone?	☐**Yes** ☐**No**
Is the member currently in acute opioid withdrawal?	☐**Yes** ☐**No**
Is the member currently taking any opioids?	☐**Yes** ☐**No**
If yes, please provide name(s): _____	
Has the member been opioid-free for a minimum of 7 to 10 days before starting naltrexone?	☐**Yes** ☐**No**

For Alcohol Dependence:	**Please submit documentation of active participation in a comprehensive management program which includes psychosocial support.** ☐ Documentation enclosed ☐Documentation unavailable
For Opioid Dependence:	**Please submit documentation of a recent urine drug screen, including date of test. Testing should include opioids.** ☐ Documentation enclosed ☐Documentation unavailable
	Please submit documentation of active participation in a comprehensive management program which provides psychosocial support, including: • **Documentation of an initial evaluation or scheduled appointment with a licensed Drug & Alcohol Provider to determine the recommended level of care** • **Documentation of referral to or enrollment in formal behavioral health counseling and/or substance abuse counseling that is consistent with the level of care recommended at the initial evaluation. Initial treatment must be performed by a licensed Drug & Alcohol Provider or a behavioral health provider.** ☐ Documentation enclosed ☐Documentation unavailable

Please be sure to complete the 2nd page of this form.

VIVITROL

Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include this page with the 1st page of this form.

Is this request for reauthorization? ☐ **Yes** ☐ **No**

If yes, please include the following documentation:

☐ **Documentation showing member's disease has stabilized**	☐ **Documentation showing the member is not on opioids**
☐ **Documentation of active participation in at least monthly formal behavioral health counseling, substance abuse counseling, or an addiction recovery program.**	☐ **Documentation of a recent urine drug screen, including date of test (for diagnosis of opioid dependence). Testing should include opioids.**

Please provide any additional information which should be considered in the space below: