

Todav	's date:	Intended date of injection:	

Prior Authorization Form – Vivitrol®

ONLY COMPLETED REQUESTS WILL BE REVIEWED.									
Check one: ☐ New start ☐ Continued treatment									
Pā	atient information (please print)	Physician ir	Physician information (please print)						
Pat	tient name	Prescribing phys	Prescribing physician						
Ad	dress	Office address	Office address						
Cit	y, state, ZIP	City, state, ZIP							
Pat	tient telephone #	Office contact	Office contact						
Pat	tient ID	Office telephone	Office telephone #						
Da	te of birth	Fax #	NPI	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)	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?				□No				
	b. Is the patient currently participating in a comprehensive 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?				☐ No				
	e. Has the patient abstained from alcohol prior to administration of naltrexone (Vivitrol*)?				□ No				
	f. Has the patient abstained from opioids at least 7-10 day			☐Yes	□No				
3) Prescription information									
	Quantity	refill x	month(s)						
	Instructions (include dose) every day(s)/ week(s)/ mont								
Physician's signature									

Please fax this completed form to 215-761-9580.