MHLA Naltrexone Injection (Vivitrol®) Prior Authorization Form

Instructions

1. Please fill out all sections of the form on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes, lab data, to support the PA request. Incomplete forms will be filed as incomplete.
2. Submit complete form along with complete documents via Email: priorauth@dhs.lacounty.gov or Fax: 310-669-5609
3. **Submit Vivitrol Patient Assistance Program Application immediately to Alkermes**

Notes

1. Authorizations are limited to **ONE** dose of therapy. Subsequent doses will be supplied by Alkermes Vivitrol PAP. If Alkermes rejects the patient, send a copy of the rejection letter.
2. Please complete **ALL** areas below, as incomplete prior authorization requests **MAY AFFECT THE OUTCOME** of this request.

Patient Information: This must be filled out COMPLETELY to ensure HIPAA compliance			
First Name:	Last Name:	MI:	Phone Number:
Address:	City:	CA	Zip Code:
Date of Birth:	☐ Male ☐ Female	Height : Weight:	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	
Insurance/Coverage Information			
Primary Insurance/Coverage Name: **My Health LA**		MHLA Patient ID Number:	
Prescriber Information			
First Name:	Last Name:	Specialty:	
Address:	City:	CA	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			
Vivitrol® Prescription Information			
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

☐ **New Therapy**

Medication History for This Condition

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

☐ **Renewal**

Date of Therapy Initiated: _____

Date of Last Dose Given: _____

Duration of Therapy (specific dates): _____

How did the patient receive the medication?

- ☐ Patient Assistance Program
  - ☐ Requesting gap coverage for PAP renewal
  - ☐ PAP denied, please attach denial letter
- ☐ Other (explain): _____

LA County DHS P&T Committee Approved: 6/2018

MHLA Naltrexone Injection (Vivitrol®) Prior Authorization Form Continued

Patient Name:	MHLA Patient ID#:

STEP 1: EXCLUSION CRITERIA *(If any of the following criteria apply, the patient does **NOT** qualify for injectable naltrexone use)*	
Patient has been on a short-acting opioid within the past seven days	Patient has been on a long-acting opioid within the past fourteen days
Patient currently in acute opioid withdrawal	Patient has severe liver impairment with AST or ALT over five times the upper limit of normal, OR moderate-severe renal impairment
Patient requiring opioid therapy for pain	

STEP 2a: APPROVAL CRITERIA FOR Alcohol Use Disorder *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval. **None** of the exclusion criteria above apply.)* **Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.	
☐	Patient has been opioid free for at least seven days from short-acting opioids and fourteen days from long-acting opioids
☐	Oral naltrexone failed to reduce alcohol consumption in the patient or in situations where patient's ability or likelihood of participating in oral maintenance medication treatment is poor
☐	Vivitrol Patient Assistance Program Application has been submitted to Alkermes. Date of PAP application submitted _____

STEP 2b: APPROVAL CRITERIA FOR Opioid Use Disorder *(Check **ALL** criteria that apply, **ALL** lines must be checked for approval. **None** of the exclusion criteria above apply.)* **Note:** Any incomplete information **MAY AFFECT THE OUTCOME** of this request.	
☐	Patient has been opioid free for at least seven days from short-acting opioids and fourteen days from long-acting opioids
☐	Patient has failed or has contraindications to Buprenorphine containing regimen (Buprenorphine or Buprenorphine/Naloxone), such as an allergic reaction, worsened opioid use while taking Buprenorphine, or history of documented significant diversion or inadherence to buprenorphine
☐	Vivitrol Patient Assistance Program Application has been submitted to Alkermes. Date of PAP application submitted _____

STEP 3: DOSAGE *(Check the appropriate dosage)*	
☐ 380mg intramuscularly every 4 weeks	☐ Other: _____

STEP 4: ADDITIONAL EXPLANATION *(For additional comments, please attach to form)*

STEP 5: ATTACH RELEVANT DOCUMENTS, PROGRESS NOTES, LABS, and CURRENT MEDS *(Required)*

STEP 6: PRESCRIBER SIGNATURE

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date**: _____

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Plan Use Only:

Pharmacy Review: Approval criteria met? ☐ **YES** ☐ **NO**
See instructions at top of form for next step following review.

Date Received:	Date of Decision:
Pharmacist Reviewer:	

Medical Review:	☐ **Approved**	☐ **Denied**
Date Received:	Date of Decision:	
CMO or Designee:		

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