Vivitrol® (naltrexone) Injectable
Prior Authorization Request Form

For assistance, please call 1-800-544-3907 or fax completed form to 570-271-5534.

Medical documentation may be requested. This form will be returned if not completed in full.

Patient Information			**Prescriber Information**		
Patient Name:			*Prescriber Name:* *Prescriber Specialty:*		
Member ID#:			*NPI or Tax ID#(if available):*		
Address:			*Address:*		
City:	*State:*		*City:*		*State:*
Home Phone:	Zip:		*Office Phone #:*	*Office Fax #:*	*Zip:*
Sex (circle): M F	DOB:		*Contact Person:*		
Height/Weight:	*Drug Allergies:*				
Medication Requested: ☐ *Brand* ☐ *Generic*	*Strength and Route of Administration:*		*Frequency:*		
Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.					
☐ *New Prescription* ☐ *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 injection: ☐ *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*		
Prescriber's Signature:			*Date:*		

Please complete the following for ALL requests:		
Does the member have acute hepatitis or liver failure?	☐ *Yes*	☐ *No*
Does the member currently drink alcohol?	☐ *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? *If yes, please list*:	☐ *Yes*	☐ *No*
Has the member taken opioids within the past 7 days? If yes, please list:	☐ *Yes*	☐ *No*
If yes, please provide name(s):		
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 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 for reauthorization:	
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 to be considered in the space below:	

Instructions for Completing the Form

1. Submit a separate form for each medication.

2. Complete **ALL** information on the form.
   NOTE: The prescribing physician should, in most cases, complete the form.

3. Please be sure to provide the physician address in a legible format, as it is required for notification.

4. Once form is completed, mail or fax to:

   Geisinger Health Plan
   Attn: Office of Medical Director 32-20
   100 N. Academy Avenue
   Danville, PA 17822
   Fax: 570-271-5534