Montana Healthcare Programs
VIVITROL® (Naltrexone Extended Release Injectable Suspension)
Prior Authorization Request Form

Please read and complete.

Patient Name **Patient Medicaid ID** **Patient DOB**

Provider Name

Provider Telephone **Provider Fax**

Drug Dose/Directions

☐ Provider is a Montana Healthcare Programs enrolled provider and as such, adheres to the requirements in the Addictive and Mental Disorders Division (AMDD) Policies. The complete policies are found at AMDD Medicaid Services Provider Manual (mt.gov).

☐ Provider attests patient Treatment Plan includes ***all*** of the following and ***is documented*** in the patient chart. **Chart notes do not need to be sent unless specifically requested.**

1. Member is 18 years of age or older. ◯ **Yes** ◯ **No**
2. Member is opioid free for a minimum of 7-10 days or has demonstrated a negative naltrexone or naloxone challenge. ◯ **Yes** ◯ **No**
3. Provider attests that VIVITROL® will not solely be used for the treatment of methamphetamine use disorder. ◯ **Yes** ◯ **No**
4. Behavioral health assessment and engagement in counseling will be recommended. ◯ **Yes** ◯ **No**
   **If the recommendation is accepted, referral assistance will be provided if resources are available. If patient is not ready for change, periodic re-assessment of readiness will occur. Lack of counseling is not a reason to withhold treatment.
5. Screening/assessment supports a diagnosis of the following. Check the appropriate box.

   ☐ **Alcohol Dependence**
   Please provide clinical rationale why oral naltrexone is not appropriate for the member.

   ☐ **Opioid Use Disorder**
   Please provide clinical rationale why buprenorphine-containing products are not appropriate for the member.

Note: Opioids will be placed on non-covered status if VIVITROL® is approved.

Provider Signature _____ Date_____

Please complete form and fax to the Montana Healthcare Programs Drug Prior Authorization Unit at (800) 294-1350.