BANK'S APOTHECARY

Specialty Pharmacy

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date.
Fax signed forms to Aetna Better Health Pennsylvania Medicaid/Aetna Better Health Kids at **1-877 -309-8077**. Please contact Aetna Better Health Pennsylvania Medicaid at **1-866-638-1232** or Aetna Better Health Kids at **1-800-822-2447** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Vivitrol (PA88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

[ ] Vivitrol (naltrexone for extended-release injectable suspension)

[ ] Other, Please specify: _____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please check the appropriate answer for each question.

1. Has Aetna Better Health of Pennsylvania authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? [ ] Y [ ] N

   [If no, skip to question 3.]

2. Does the patient meet ALL of the following criteria: A) Is compliant with Vivitrol injection appointments, B) Has submitted a urine drug screen, and C) Is participating in a substance abuse treatment program or psychosocial support plan? [ ] Y [ ] N

   [No further questions.]

3. Is Vivitrol requested for treatment of alcohol dependence? [ ] Y [ ] N

   [If no, skip to question 6.]

4. Has the patient been abstinent from alcohol for at least 4 days prior to initiating Vivitrol? [ ] Y [ ] N

   [If no, then no further questions.]

5. Has the patient experienced treatment failure or intolerable side effects with oral naltrexone or disulfiram? [ ] Y [ ] N

   If no, please document rationale for Vivitrol use over oral agents:

   _____

   [If yes, skip to question 7.]

   [If no, then no further questions.]

6. Is Vivitrol requested for a patient with opioid dependence? [ ] Y [ ] N

   [If no, then no further questions]

7. Has the provider confirmed through a naloxone challenge test OR a negative urine drug screen for opioids that the patient has not used opioids within the previous 7 days? [ ] Y [ ] N

   [If no, then no further questions.]

8. Has the patient submitted a urine drug screen that was negative for all substances of abuse? [ ] Y [ ] N

   [If no, then no further questions.]

9. Will the patient be enrolled in a substance abuse treatment program or psychosocial support/recovery plan? [ ] Y [ ] N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**