Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Vivitrol (Medicaid)

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 New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Vivitrol (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Vivitrol (naltrexone)

Other, specify drug _____

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:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 5.]

2. Is the member compliant on the requested medication? Y N

   Note: Claims history will be reviewed to verify compliance.

   [If no, then no further questions.]

3. Has the member completed a urine drug screen? Y N

[If no, then no further questions.]

4. Is the member compliant with a substance use treatment program or psychosocial support plan? Y N

   [No further questions.]

5. Does the member have a diagnosis of alcohol dependence? Y N

   [If no, skip to question 7.]

6. Is the member actively drinking alcohol at the time of initial treatment? Y N

   [If yes, then no further questions.]

   [If no, then skip to question 8.]

7. Does the member have a diagnosis of opioid dependence? Y N

   [If no, then no further questions.]

8. Has the member been opioid free for a minimum of 7-10 days prior to initiation of therapy including pertinent lab testing (e.g., a recent urine drug screen for opioids, naloxone challenge test)? Y N

   [If no, then no further questions.]

9. Is there documentation of a plan for the member to participate in a comprehensive treatment program for alcohol or opioid dependence that includes a psychological support system within 90 days of initiation of naltrexone therapy? Y N

   [If no, then no further questions.]

10. Is the member 18 years of age or older? 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**