Magellan HEALTHCARE SM

Vivitrol Injection Request Form
Fax to Magellan: 1.888.656.4916

(All requests must be approved in advance to insure authorization)

Today's Date: _____

Member Name: _____ Medicaid ID #: _____

Provider: _____ Contact: _____

Contact Phone Number: _____ Provider MIS #: _____

Service Location: _____

Current Diagnosis: _____

_____

Prescribing Physician/NP: _____ **Phone:** _____

Date of negative UDS: _____

Please list all current medications: _____

_____

_____

_____

Guidelines for Approval (NMAP/NMMCP)

1. Client has been diagnosed with Alcohol and/or Opioid Dependence.
   ☐ Yes ☐ No

2. Clients must be free of all opioid use, from any source, for a minimum of 7-10 days before the first injection.

3. Client does not require prescribed opioid dependence. Client must be free of all opioid use, from any source, for a minimum of 7-10 days before the first injection.

4. Medical clearance to begin treatment with Vivitrol has been obtained in writing.

   MD Name: _____ **Date of Examination:** _____

5. Oral medications are medically contraindicated. Documentation should include client-specific reasons why oral medications are unsafe or not appropriate.

   _____

   _____

   _____

6. Client has signed an agreement to participate in a comprehensive substance use disorder treatment program while receiving Vivitrol.
   Name of SA Program: _____

Exclusion Guidelines

Vivitrol *will not be authorized if any of the following are true:*

1. Client is under 16 years of age
2. Client is pregnant or may become pregnant during treatment with Vivitrol. Client is breastfeeding.
3. Client is physically dependent upon opioids. Vivitrol will cause rapid onset of acute withdrawal from opioids. Attempts to obtain the usual opioid effects by taking larger doses than usual may be fatal.
4. Client requires opioid containing medications, either occasionally or on an ongoing basis, for medical treatment. Examples include pain management, control of diarrhea, or as a cough suppressant.
5. Client is not compliant with the required comprehensive substance use disorder treatment.

Dosage Information for Authorization:

Please extend authorization for: ☐ 3 months ☐ 2 months ☐ 1 month

Dosage given on each appointment date: (mg)

Dates of injections:			

J (Vivitrol) x Units
96372 (injection) x (number of injections)

Authorization #: _____

Please fax this form with the authorization number back to Provider: ☐ Provider Fax #: _____

Please call us back with authorization #: ☐ Provider Contact Phone #: _____