9/01/2013

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS

Vivitrol (IL88)

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 Illinois at 1-855-684-5250.
Please contact Aetna Better Health Illinois at 1-866-212-2851 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Vivitrol (IL88).

Drug Name (select from list of drugs shown)

Vivitrol (naltrexone ER) injection

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: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Does patient have any of the following? Y N

   Age less than 18 years old \ Hypersensitivity to naltrexone or any components of the commercially available product \ Acute hepatitis or hepatic failure [Black Box Warning] \ Currently receiving opioid analgesics \ Currently experiencing opiate withdrawal

   [If yes, no further questions.]

2. Is Vivitrol requested for treatment of alcohol dependence? Y N

   [If no, skip to question 6.]

3. Is the request for initial therapy? Y N

   [If no, skip to question 10.]

4. Does the patient meet ONE of the following? Y N

   Inadequate response to oral naltrexone, Campral and/or disulfiram OR \ Intolerance to oral naltrexone, Campral and /or disulfiram OR\ Non-compliant with oral naltrexone, Campral and/or disulfiram OR \ Prescriber-provided rationale to support the necessity of Vivitrol injections Please document which of the above apply to patient or document prescriber-provided rationale: _____
   _____

   [If no, no further questions.]

5. Has the patient been abstinent from ALCOHOL and OPIATES for at least 7 days in an ambulatory setting? Y N

   Note: (to prevent unintentional withdrawal, patient should pass naloxone challenge test or have negative urine drug screen for opiates)

   [If yes, skip to question 10.]

   [If no, no further questions.]

6. Is Vivitrol requested for the prevention of relapse to opioid dependence? Y N

   [If no, no further questions]

7. Is the request for initial therapy? Y N

   [If no, skip to question 10.]

8. Does the patient meet ONEof the following? Y N

   Inadequate response to oral naltrexone and/or oral buprenorphine with or without naloxone (Subutex or Suboxone) OR \ Intolerance to oral naltrexone and/or oral buprenorphine with or without naloxone (Subutex or Suboxone) OR \ Non-compliant with oral naltrexone and / or oral buprenorphine with or without naloxone (Subutex or Suboxone) OR \ Prescriber-provided rationale to support the necessity of Vivitrol injections Please document which of the above apply to patient or document prescriber-provided rationale

   [If no, no further questions.]

9. Has the patient been abstinent from OPIATES for at least 7 days in an ambulatory setting? Y N

Note: (to prevent unintentional withdrawal, patient should pass naloxone challenge test or have negative urine drug screen for opiates)

10. Will the patient be enrolled in (or, Is the patient enrolled in and compliant with) a substance abuse treatment program or psychosocial support plan? Y N

    [If no, no further questions.]

11. Will random urine drug screening be used (or, Has random urine drug screening been used) to verify patient has remained abstinent from using all substances of abuse? Y N

    [No further questions.]

Comments:

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

Prescriber (Or Authorized) Signature Date