Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Vivitrol

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 Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Vivitrol.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Vivitrol (naltrexone)

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 circle the appropriate answer for each question.

1. Does the member have a documented diagnosis of alcohol dependence? Y N
   [If no, skip to question 3.]

2. Is the member abstaining from alcohol consumption? Y N
   [If yes, skip to question 5.]
   [If no, no further questions.]

3. Does the member have a documented diagnosis of opioid dependence? Y N
   [If no, no further questions.]

4. Has the member successfully completed an opioid detoxification program? Y N
   [If no, no further questions.]

5. Is the member 18 years of age or older? Y N
   [If no, no further questions.]

6. Is the member currently taking opioid analgesics (e.g. for pain management), physiologically dependent on opioids, or in acute opioid withdrawal? Y N
   [If yes, no further questions.]

7. Has documentation been submitted demonstrating tolerability to oral naltrexone? Y N
   [If no, no further questions.]

8. Has documentation been submitted indicating opioid free for a minimum of 7-10 days prior to therapy initiation including pertinent laboratory testing (e.g. recent [within the past two weeks] urine drug screen for opioids, or naloxone challenge test)? Y N
   If no, no further questions.]

9. Does the member actively participate in a rehabilitation program that includes psychosocial support and counseling? Y N
   [If no, no further questions]

10. Is the request for continuation of therapy? Y N
    [If no, no further questions.]

11. Has the member been consistently receiving injectable naltrexone (i.e. pharmacy claims/progress notes)? Y N
    [If no, no further questions.]

12. Has documentation been submitted indicating the member has remained abstinent from all substances of abuse? Y N
    [If no, no further questions.]

13. Has documentation been submitted indicating that the member is actively participating in psychosocial support with counseling? 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