Maryland Medicaid
Pharmacy Program
Fax: (866) 440-9345
Phone: (800) 932-3918

Vivitrol / Campral
Prior Authorization Form

MARYLAND
Department of Health

Patient's Information: **Date:** ______________

Name: ____ DOB: _____________________

Participant's Maryland Medicaid Number: ____________________________

Prescriber's Information:

Name: ____NPI #: _________________

Phone #: ___________________ Fax #: ______________________

Contact Person for this Request:

Name: _________________________________ Phone: ________________ Fax: _______________

Medication: ___________________________ Strength: ________ Quantity: _____ Refills: _____

Directions for Use: _______________________________________

Check each box below that applies for the requested medication.

Vivitrol Criteria

☐ Please indicate diagnosis of opioid or alcohol use disorder (circle one)

☐ Negative urine test results for opioids or MD to provide documentation that the patient has passed a naloxone challenge test in the past 7 days

☐ Attest patient is abstinent from alcohol (Required for alcohol use disorder only)

Campral Criteria

☐ Diagnosis of alcohol use disorder

☐ Negative test result for alcohol in the past 7 days

☐ History of Naltrexone or Disulfiram therapy

☐ Creatinine Clearance is > 50 ml/min

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I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber's Signature______________________________ Date___________________

Fax this completed form to 866-440-9345, once all the required information has been provided. **Incomplete forms will not be reviewed**.

https://store.samhsa.gov/shin/content/SMA14-4892R/SMA14-4892R.pdf https://www.vivitrol.com/content/pdfs/prescribing-information.pdf

Internal Use only- Information below is to be completed by the PA pharmacist

For Vivitrol Criteria ☐ No opioid claim in the past 7 days
For Campral Criteria ☐ Claims history of Naltrexone or Disulfiram therapy