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

Vivitrol / Campral Prior Authorization Form

Date __ __ - __ __ - __ __

Patient's Information:

Name: _____ DOB: _____

Recipient'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: _____ **Length of Treatment** _____

Please check each box below that applies for the requested medication.

Vivitrol Criteria	**Campral Criteria**
☐ Diagnosis of opioid or alcohol use disorder	☐ Diagnosis of alcohol use disorder
☐ Negative urine test results for opioids or Prescriber to provide documentation that the patient has passed a naloxone challenge test in the past 7 days	☐ Negative test result for alcohol in the past 7 days
☐ Negative test result for alcohol in the past 7 days (Required for alcohol use disorder only)	☐ History of Naltrexone or Disulfiram therapy
☐ Patient is enrolled in a comprehensive management program including psychosocial support.	☐ Patient is enrolled in a comprehensive management program including psychosocial support.

Additional Info: _____

I certify that the above information is accurate and will be made available for audit if requested.

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**.

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