

VIVITROL® IM Physician Prior Authorization

ATTENTION

In order for Health Care Authority (HCA) to reimburse for this medication, the patient listed below **must currently** be enrolled in state-certified chemical dependency treatment and meet the attached criterion for this medication. Complete Sections 1 through 4 of the form. Instructions for proper completion are on page 3 of this form. **Send the completed form to the Division of Behavioral Health and Recovery (DBHR) by fax at 360-586-0343 for review.**

1. CHEMICAL DEPENDENCY TREATMENT AGENCY SECTION

NAME OF DBHR CERTIFIED CHEMICAL DEPENDENCY TREATMENT AGENCY	AGENCY NUMBER (FOUND IN "DIRECTORY OF CERTIFIED SERVICES IN WASHINGTON")
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2. PATIENT SECTION

PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

PATIENT NAME	DATE OF BIRTH	MEDICAID PROVIDER ONE NUMBER
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The above-named patient hereby authorizes the following entities to exchange and disclose to one another information concerning the patient's name and other personal identifying information, their status as a patient, diagnosis, recommended medication(s) and the treatment recommendations(s):

- The CDP and/or certified chemical dependency treatment agency in Section 1 above.
- Department of Social and Health Services - Division of Behavioral Health and Recovery.
- The physician named in Section 3 below.
- Health Care Authority
- The pharmacy named in Section 4.

The purpose of this authorization for disclosure is:

- To initiate an authorization to obtain a prescription for **Vivitrol® IM** and coordinate care.
- To verify patient's involvement in state-certified chemical dependency treatment.

I understand that my alcohol and/or drug treatment records are protected under Federal and State confidentiality regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: six (6) months from the date signed or the **following specific date, event, or condition upon which this consent expires:**

(Specify the date, event, or condition) _____

PATIENT'S SIGNATURE	DATE	SIGNATURE OF GUARDIAN OR AUTHORIZED REP (WHEN REQUIRED)	DATE
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3. PHYSICIAN SECTION

PHYSICIAN'S NAME	NPI NUMBER	PHYSICIAN'S PHONE NUMBER
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PHYSICIAN'S ADDRESS	CITY	STATE	ZIP CODE	PHYSICIAN'S FAX NUMBER
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DATE ORDERED	PROPOSED START DATE	VIVITROL® DOSE	EXPECTED DURATION OF THERAPY
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The patient must meet DSM IV TR CRITERIA or its successor.

Alcohol Dependence **Opiate Dependence** **BOTH Alcohol and Opiate Dependence**

In the past year, has the patient:

- Had two unsuccessful attempts at short-term detoxification or chemical dependency treatment
- Tried and failed oral naltrexone for alcohol or opiate dependence
- Tried and failed Campral for alcohol dependence

In the past year, has the patient had three or more:

- Emergency Room visits
- Hospital Admissions
- Services for alcohol or drug related illness, injury or detoxification

DECLARATION

I understand that **Vivitrol® IM** must be administered by a licensed health care provider. Reimbursement by HCA for **Vivitrol® IM** is limited to twenty-four (24) weeks of continuous use and shall only be made under the attached criterion conditions.

- | | Yes | No |
|--|--------------------------|--------------------------|
| • If Alcohol Dependent: Has the patient achieved alcohol abstinence one week prior to beginning Vivitrol® IM treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does the patient have renal impairment? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does the patient have acute hepatitis, liver failure, or active liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| • What other treatment alternatives have been tried? | | |

The efficacy of **Vivitrol® IM** in promoting abstinence has not been demonstrated in patients who have not completed detoxification and achieved alcohol or opiate abstinence prior to beginning **Vivitrol® IM** treatment.

PHYSICIAN'S SIGNATURE

DATE

4. PHARMACY SECTION

PHARMACY NAME

TELEPHONE NUMBER

FAX NUMBER

PHARMACY ADDRESS

CITY

STATE

ZIP CODE

I have verified that **Vivitrol® IM** will be dispersed to and administered by a health care provider in a medical facility: Yes No

NPI NUMBER

PHARMACIST'S SIGNATURE

DATE

FOR DBHR USE ONLY: APPROVED DENIED BASED ON: _____

DBHR SIGNATURE: _____ DATE: _____ SENT TO PHARMACY YES

NOTICE PROHIBITING REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT INFORMATION

Prohibition on Rediscovery of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

VIVITROL® IM Physician Prior Authorization Instructions

This **Vivitrol® IM Physician Prior Authorization** form must be completed and submitted before administration of the medication in order for HCA to pay for the medication. The Chemical Dependency Treatment Agency or the prescribing physician may initiate this form.

A. Complete **SECTION 1. CHEMICAL DEPENDENCY TREATMENT AGENCY SECTION:**

Enter the name of the DBHR certified chemical dependency treatment agency and the agency's 8-digit certification agency identification number found in the "Directory of Certified Chemical Dependency Services in Washington State" published by DBHR, found at:

- <http://www.dshs.wa.gov/dbhr/dadirectory.shtml>.
- The physician keeps a copy of the **Vivitrol® IM Physician Prior Authorization** form in the medical record.
- The physician's office faxes the completed **Vivitrol® IM Physician Prior Authorization** form to the pharmacy.

B. Complete **SECTION 2. PATIENT SECTION:**

- Enter the patient's name and Medicaid ProviderOne ID number.
- Complete the **Patient Authorization for Disclosure of Confidential Information**, being sure the CDP discusses this disclosure with the patient, have the patient sign, and date it (or their guardian or authorized representative, when required). Then the form goes to the Physician.

C. Complete **SECTION 3. PHYSICIAN SECTION:**

- Enter the name of the patient and physician.
- Enter the physician's address, telephone number, Fax number, Medicaid provider number, date ordered, proposed start date, dose, and expected duration.

Physician verifies the patient meets the attached criterion by completing the declaration.

- The physician keeps a copy of the **Vivitrol® IM Physician Prior Authorization** form in the medical record.
- The physician's office faxes the completed **Vivitrol® IM Physician Prior Authorization** form to the pharmacy.

D. Complete **SECTION 4. PHARMACY SECTION:**

- Enter the name of the pharmacy, telephone number, fax number, and address.
- Verify the medication is being dispensed to and administered by a health care provider in a medical facility.
- Pharmacist signs and dates the form.
- The pharmacy keeps a copy of the **Vivitrol® IM Physician Prior Authorization** form for their records.
- The pharmacy will fax the completed **Vivitrol® IM Physician Prior Authorization** form to DBHR at (360) 586-0343 for authorization. This must be done before medication is dispensed and administered.

E. **Steps for Authorization or Denial by HCA:**

- Once DBHR receives the completed **Vivitrol® IM Physician Prior Authorization** form, the patient's status in a state certified chemical dependency treatment program will be verified. The **Vivitrol® IM Physician Prior Authorization** form will be routed to HCA pharmacy authorization for approval or denial to pay.
- Then HCA will notify the physician's office or the pharmacy of approval or denial to pay.

Authorization Criteria for Vivitrol® IM

Health care Authority will cover Vivitrol® IM for the following two Medicaid client-types providing the appropriate criteria is met:

Clients who have had two documented unsuccessful attempts at short-term detoxification or drug-free treatment at a DBHR-certified chemical dependency treatment program and who meet the following criteria:

- Must have tried and failed oral naltrexone or Campra®; and
- Must abstain from alcohol one week prior to treatment if for alcohol dependence and must be opioid-free.

Clients who frequent public emergency rooms, hospitals, or detoxification services for alcohol-related illness, injury, detoxification, etc who meet the following criteria:

- Must have had three such admissions within the last year, and
- Must have just been through alcohol and/or opioid detoxification; or
- Must have not used alcohol for one week if for alcohol dependence and must be opioid-free.

All of the following must be met for both client types:

- Used for the treatment of alcohol dependence or opioid dependence (as defined by DSM-IV criteria).
- Currently enrolled in a DBHR certified Chemical Dependency treatment program.
- Each IM injection (no more than 380mg/injection) must be given by a physician or nurse once every 4 weeks.
- **Not using opioid narcotics concurrently because Vivitrol® IM could cause immediate and severe opioid withdrawal.**
- **Does not have acute hepatitis, liver failure, or active liver disease (AST or ALT > 3 times the upper limit of normal).**
- **Does not have severe renal impairment.**

Treatment is limited to 6 doses in 24 weeks; extensions to be determined on case by case basis.