Arkansas Medicaid Medication Assisted Treatment (MAT) Pharmacotherapy
VIVITROL® (naltrexone ER IM injection)
Statement of Medical Necessity

After completion of this form, please **fax** to the CareSource PASSE Pharmacy Program. **Fax: 1-866-930-0019**
For questions call CareSource PASSE Provider Services: 1-833-230-2100

CareSource PASSE Provider NPI:	**CareSource PASSE Beneficiary ID Number:**
Prescriber Name:	**Beneficiary Name:**
Address:	**Address:**
City: State: Zip:	**City: State: Zip:**
Phone: ( )	**Patient's Date of Birth: / /**
Fax: ( )	
NAME OF PERSON (NURSE OR CLINIC REPRESENTATIVE) TO CONTACT IF THERE IS ADDITIONAL INFORMATION NEEDED FOR PA PROCESSING:	**PLEASE INDICATE UNDER WHICH BENEFIT THIS CLAIM WILL BE BILLED:** ☐ **PHARMACY** ☐ **MEDICAL**
Medication requested: ☐ **VIVITROL® 380MG IM Injection**	**QUANTITY EDITS APPLY**

Per SAMHSA--Medication-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

Initial PA request (Once the following information is provided, the PA can be approved for 6 months):

a. Indicate reason for PA request for VIVITROL IM injection:

Opioid Use Disorder	YES ☐	NO ☐
Alcohol Use Disorder	YES ☐	NO ☐
Mixed Opiate/Alcohol Dependence	YES ☐	NO ☐

b. Did the beneficiary have evidence of oral naltrexone tolerability? YES ☐ NO ☐
c. Provide current chart notes;
d. Provide liver function test results (VIVITROL® IM is not approved for Child-Pugh C classification); **AND**
e. Provide the current urine drug screen test results (specifically testing for opioids).

Renewal request (Once the following information is provided, the PA can be extended 6 months):

a. Provide current chart notes; **AND**
b. Provide current urine drug screen test results (specifically testing for opioids); **AND**
c. Provide the date of the beneficiary's last Vivitrol® injection ___________________________
d. Do you attest that this patient is receiving regular behavioral health counseling in conjunction with taking this medication? YES ☐ NO ☐

Prescriber Signature: ____ **Date:** ____________________

Prescriber's original signature required; copied, stamped, or e-signature are not allowed. By signature the prescriber confirms the criteria information above is accurate and verifiable in patient records.

******Please note that all information attested to herein is subject to Medicaid review and audit.********