AMIDA CARE LIVE LIFE PLUS

VIVITROL ENROLLMENT REQUEST FOR MEDICAID MEMBERS

Vivitrol (naltrexone for extended-release injectable suspension)

Please fax form to Amida Care: 1-646-786-0997

This enrollment form must be filled out by the prescriber and faxed to the number above. Once the fax has been received the prescriber and member will be contacted with shipment information within **1** business day. The medication will then be delivered to the prescriber's facility for administration by a healthcare professional.

Completion of this form will allow Amida Care to work in conjunction with prescribers to monitor adherence and improve health outcomes. Please fill out the form in its entirety and write clearly to avoid any delays in care.

PRESCRIBER INFORMATION	MEMBER INFORMATION
Name:	Member Name:
NPI:	Amida Care ID #:
Address:	Address:
Office Phone #:	Member Phone #:
Office Fax #:	
Contact Person:	

MEDICATION REQUESTED

Start Date of Treatment: ___/___/____

Prescriber specialty: _____

Medication/s Requested :

☐ Vivitrol

(Quantity limits apply):

One vial per 28 days of Vivitrol 380mg strength

Is the request to exceed the quantity limit?

☐ Yes ☐ NO

If Yes, please provide rational and supporting documentation as to why the QL will be exceeded:

_____

_____

MEDICAL DIAGNOSIS AND CLINICAL CRITERIA

Please indicate the Diagnosis code/description indicated for use of Vivitrol injection.

DX code/description: _____

Medication History

Please list any previous SUD medications the member has taken?

Medications Used	Duration/ Year	Outcome
	/	
	/	
	/	

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Is the patient currently abstaining from alcohol and opioid use?

☐ YES ☐ NO

If yes, for how long? _____

Is the patient currently participating in a substance abuse or mental health program?

☐ YES ☐ NO

If yes, please provide name of program(s) and date(s):

_____

Please call 646-757-7979, M-F, 9 - 6 PM if you have any questions.

_____ _____

Prescriber or Authorized Signature Date