MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND
PO BOX 1501 • 1400 DISTRICT AVENUE
BURLINGTON, MASSACHUSETTS 01803
TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX (781) 238-0703

Vivitrol Prior Authorization Form

Physician's office must complete form in its entirety and fax back to 781-238-0703.

Patient Information:

Patient Name:	Member ID#
Patient Address:	
Date of Birth:	Telephone number:

Physician Information:

Prescribing Physician Name:	Physician Phone Number:
Physician Address:	
Office Contact Name:	Physician Tax ID#/NPI #:

Check One: ☐ Initial Authorization ☐ Reauthorization
(Authorization limited to 6 months at a time, with a maximum of 24 authorized months in a lifetime)

Approval Criteria: Check all boxes that apply		
Patient is being treated for Opioid dependence	☐ Yes	☐ No
Patient has successfully completed an Opioid detoxification program	☐ Yes	☐ No
Patient has been opioid free for at least 7 days	☐ Yes	☐ No
Patient is taking Opioid Analgesics for Pain management	☐ Yes	☐ No
Patient Failed the Naloxone challenge test	☐ Yes	☐ No
Patient had a positive urine screen for opiates	☐ Yes	☐ No
Patient is diagnosed with acute hepatitis or liver failure	☐ Yes	☐ No
Patient has had a previous hypersensitivity to naltrexone	☐ Yes	☐ No
Patient actively participates in a comprehensive rehabilitation program that includes psychosocial support	☐ Yes	☐ No

Physician's office must complete form in its entirety and fax back to 781-238-0703.

For Reauthorization Requests Only: Please attach the required documentation

Please submit a letter of Medical Necessity indicating the clinical rationale for continued treatment for the prevention of relapse. Reauthorization requests will not be considered without required documentation.

Patient continue to participate in a comprehensive rehabilitation program that includes psychosocial support ☐ Yes ☐ No

Patient has significant improvement as evidenced by complete abstinence from opiate use ☐ Yes ☐ No

Please provide any additional information that should be considered in the space below:

Physician Signature Date