



Partnering within our communities to provide solutions for better health

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**Montana Healthcare Programs Prior Authorization Request Form for Use of  
Vivitrol (naltrexone extended release injectable suspension)**

Member Name:	Member ID#:	Member DOB:
Provider Name:	Provider Fax#:	
Provider Phone #:	Drug Dose/Directions:	

**Provider attests patient treatment plan includes all of the following and will be documented** in patient chart (case notes do not need to be sent unless specifically requested):

1. Provider is a Montana Healthcare Programs-enrolled provider and, as such, adheres to the requirements in the Addictive and Mental Disorders Division (AMDD) MAT policy. The complete policy can be found here: Policy Number 550 (mt.gov): ☐ Yes ☐ No
2. Member is 18 years of age or older: ☐ Yes ☐ No
3. Member is opioid-free for a minimum of 7-10 days or has demonstrated a negative naltrexone or naloxone challenge: ☐ Yes ☐ No
4. Provider attests that member has demonstrated tolerability to oral naltrexone: ☐ Yes ☐ No
5. Provider attests that Vivitrol will not be used for the treatment of methamphetamine use disorder:  
☐ Yes ☐ No
6. Behavioral health assessment and engagement in counseling will be recommended. ☐ Yes ☐ No  
*If recommendation accepted, referral assistance will be provided if resources are available. If patient is not ready for change, periodic re-assessment of readiness will occur. Lack of counseling is not a reason to withhold treatment.*
7. Screening/assessment supports a diagnosis of (check appropriate box):

☐ **Alcohol Dependence:**

Please provide clinical rationale why oral naltrexone is not appropriate for member:

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☐ **Opioid Use Disorder:**

Please provide clinical rationale why buprenorphine-containing products is not appropriate for member:

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**Note: Opioids will be placed on non-covered status if Vivitrol is approved.**

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete form and fax to Drug Prior Authorization Unit at 1-800-294-1350.