TeamstersCare Medication Prior Authorization Form

- **Complete and fax to 781-321-6501** Ph: 800-851-8326
- Standard response time is 1 to 3 business days from date received.

Acamprosate / Naltrexone

PATIENT INFORMATION	
Patient Name:	
Date of Birth:	TeamstersCare ID#:
Patient Address:	Patient Phone:

PROVIDER INFORMATION	
Provider Name:	
Contact Person (If different than prescriber):	
Office Phone:	Office Fax:

Medication Requested: Please check one

❑ **acamprosate DR (Campral)** ❑ **naltrexone tablets**

DIAGNOSIS

❑ alcohol dependence/abuse ❑ opiate dependence/abuse

Please check or circle the appropriate answer.

1. Other Alternatives **Tried or Failed**: ❑ AA/NA Addiction
   ❑ Outpatient Therapist
   ❑ Detox/Rehab
   ❑ Other_____

Doctor's Signature: Date:

FOR TEAMSTERSCARE USE ONLY	
Eligibility Verified ☐	**Notes:**
Program: Active/MSTS ☐ ERMP ☐ RRX☐	
Medication Requires PA ☐	
Prior PA? Yes☐ No ☐ If Yes, Date:	
Form Complete/Legible ☐	
Authorized ☐ Pended ☐ Denied ☐	
Patient Notified ☐ By: Date:	
Letter Sent ☐ By: Date:	**Reviewer :** **Date:**