TeamstersCare Vivitrol Prior Authorization Form

- Complete and fax to 781-321-6501. Phone: 800-851-8326
- Standard response time is 24-48 hours from date when all data is available.

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

PROVIDER INFORMATION		
Provider Name:	Degree:	Specialty:
Office Phone:	Office Fax:	

CLINICAL INFORMATION
Diagnosis (and significant history):

TREATMENT INFORMATION
Medication Requested (specify name, strength, dosing, and duration of therapy):
Please list any additional therapy (medication and other modalities):
Please list any concurrent benzodiazepine/other medications prescribed:

SIGNATURE	
Doctor's Signature	**Date**

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