Arkansas Medicaid Medication Assisted Treatment (MAT) Pharmacotherapy
SUBLOCADE® (buprenorphine SQ injection)
VIVITROL® (naltrexone ER IM injection)
Statement of Medical Necessity

After completion of this form, please **fax** to the Arkansas Medicaid Pharmacy Unit. **Fax: 1-800-424-5851**
For questions call: 1-501-683-4120.

AR MEDICAID ENROLLED PRESCRIBER ID NUMBER:	**AR MEDICAID BENEFICIARY ID NUMBER:**
Prescriber Name:	**Beneficiary Name:**
Address:	**Address:**
City: State: Zip:	**City: State: Zip:**
Phone: ( )	**Beneficiary's Date of Birth: / /**
Fax: ( )	
NAME OF CLINIC CONTACT FOR ANY ADDITIONAL INFORMATION NEEDED WITH PA PROCESSING:	**PLEASE INDICATE UNDER WHICH BENEFIT THIS CLAIM WILL BE BILLED:** ☐ **PHARMACY** ☐ **MEDICAL**
Medication/strength requested: ☐ **VIVITROL® 380MG IM** ☐ **SUBLOCADE® 100 MG SQ** ☐ **SUBLOCADE® 300 MG SQ**	**NOTE: Preferred oral buprenorphine products do not require a prior authorization. For updated preferred list, please refer to:** https://ar.magellanrx.com/ **QUANTITY EDITS APPLY**

Per SAMHSA--Medication-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

VIVITROL PA request (Once the following information is provided, the PA can be approved for 6 months):

- **a.** Indicate reason for PA request for VIVITROL IM injection:
  - Opioid Use Disorder YES ☐ NO ☐
  - Alcohol Use Disorder YES ☐ NO ☐
  - Mixed Opiate/Alcohol Dependence YES ☐ NO ☐
- **b.** Did the beneficiary have evidence of oral naltrexone tolerability? YES ☐ NO ☐
- **c.** Provide current chart notes
- **d.** Provide liver function test results (VIVITROL® IM is not approved for Child-Pugh C classification)
- **e.** Provide the current urine drug screen test results (specifically testing for opioids)

SUBLOCADE PA request (Once the following information is provided, the PA can be approved for 6 months):

- **a.** Do you attest that this patient is being treated for opioid use disorder? YES ☐ NO ☐
- **b.** Did the beneficiary have induction with a buprenorphine-containing product for a least 7 days? YES ☐ NO ☐
- **c.** Provide current chart notes
- **d.** Provide current urine drug screen test results (specifically testing for opioids)

Prescriber Signature: ____ **Date:** ____________________
Prescriber's original signature required; copied, stamped, or e-signature are not allowed. By signature the prescriber confirms the criteria information above is accurate and verifiable in patient records.

******Please note that all information attested to herein is subject to Medicaid review and audit.********