

DIVISION OF ALCOHOL AND DRUG ABUSE (DADA)
MEDICAID NALTREXONE PRIOR - AUTHORIZATION

Agency Section (To be completed by the Counselor)

SUBSTANCE ABUSE COUNSELOR (Print Name & Sign)	CERT. NO. & EXPIRATION DATE
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The certified treatment counselor listed above certifies that the patient listed below is 18 years of age or older, is alcohol or opiate dependent, with alcohol or opiate dependence as the primary addiction; has been admitted to and is currently in a Substance Abuse treatment program, funded and approved by the Division of Alcoholism and Drug Abuse; and that Substance Abuse treatment is scheduled to be provided for a maximum of sixteen (16) weeks.

PATIENT SECTION (TO BE COMPLETED BY THE COUNSELOR)

PATIENT NAME	RECIPIENT MEDICAID ID#	DATE ADMITTED TO TREATMENT	DEPENDENCY: ALCOHOL OPIATE
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PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION (TO BE COMPLETED BY PATIENT)

I, _____, authorize the certified substance abuse counselor indicated above to disclose patient identifying information, my status as a patient and their treatment recommendation to my physician and the pharmacy indicated below for the purpose of acquiring a prescription for naltrexone.

Physician: _____

Pharmacy: _____

I understand that my records are protected under Federal Confidentiality Regulations (42 CFR, Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent shall expire 90 days from the date signed. I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Patient's Signature:

Date:

PHARMACY SECTION (TO BE COMPLETED BY THE PHARMACY)

I have received a prescription for naltrexone for the patient named above from the patient's prescriber and have filled the prescription as authorized. I understand that reimbursement from Alaska Medicaid for (naltrexone) shall only be made under the following condition:

1. The recipient is Medicaid eligible,
2. The medication is provided as part of a comprehensive treatment program as verified by the certified Substance Abuse Counselor above,
3. Payment for the medication is limited to 16 weeks of continuous use. The medication is limited to a 30 day supply on each fill, not to exceed four fills,
4. The pharmacy shall include the prescribing physician's NPI Number on the Medicaid claim,
5. The pharmacy must obtain Prior-authorization from the Magellan MAP Desk prior to each fill,
5. Record of the certification shall be kept on file at the pharmacy for Medicaid audit purposes. Prescriptions reimbursed by DMA for naltrexone without this certification record on file will be considered overpayment.

Pharmacist's Signature:

Date:

See back of form for prohibition on redisclosure of information concerning the patient or information on this form.