08/06/2013

HMSA Quest (Medicaid)

HMSA QUEST (MEDICAID)

Campral (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-855-762-5206**.
Please contact CVS/Caremark at **1-855-220-5732** with questions regarding the HMSA Quest (Medicaid) process.
When conditions are met, we will authorize the coverage of Campral (Medicaid).

Drug Name (select from list of drugs shown)

Campral (acamprosate calcium)

Quantity ________ **Frequency** ________ **Strength** ________

Route of Administration ________ **Expected Length of Therapy** ________

Patient Information

Patient Name: ________
Patient ID: ________
Patient Group No.: ________
Patient DOB: ________
Patient Phone:

Prescribing Physician

Physician Name: ________
Physician Phone: ________
Physician Fax: ________
Physician Address: ________
City, State, Zip: ________

Diagnosis: ________ **ICD Code:** ________

Comments: ________

Please circle the appropriate answer for each question.

1. Does the patient have a clinical diagnosis of alcohol dependence? Y N

   [If the answer to this question is no, then no further questions required.]
2. Does clinical evidence indicate that the patient will abstain from alcohol consumption for at least 5 days prior to treatment initiation? Y N

   [If the answer to this question is no, then no further questions required.]
3. Does the patient have severe renal impairment (creatinine clearance less than or equal to 30 mL/min)? Y N

   [If the answer to this question is yes, then no further questions required.]
4. Has a trial of oral or injectable naltrexone been attempted at a clinically significant dosage and duration? Y N

   [If the answer to this question is yes, skip to question 6.]
5. Has therapy with naltrexone been documented to be clinically inappropriate for this patient for reasons such as hepatic Y N

insufficiency or chronic pain medication use?

6. Will Campral administration be a part of a comprehensive psychosocial treatment program for this patient? Y N

I affirm that the information given on this form is true and accurate as of this date.

____

Prescriber (Or Authorized) Signature and Date