

MICHIGAN
Department Of Community Health Pharmacy Program
Verification of Definitive Treatment Program
CAMPRAL® (Acamprosate)

All information on this form must be addressed. Incomplete forms will be returned only once for missing information. Mark as 'N/A' if no information is available or does not apply. Issues that remain blank after being returned once will receive a denial and will not qualify for MDCH physician review until completed or clearly marked 'N/A'.

Prescribing Physician:

Beneficiary: Male Female

Name: _____

Name: _____

First Last

First Last

Phone #:

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Medicaid #:

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Fax #:

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Date of Birth:

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NPI:

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Specialty: _____

NPI accepted as of April 17, 2007

Person completing form: _____ Rqstd start date: _____

Name

Title

Date

Pharmacy: _____

Phone #:

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Medication	Dose	Duration of Rx

Please address/confirm ALL of the following:

1. The recipient has a diagnosis of maintenance of abstinence from alcohol with a history of alcohol abuse and is abstinent at the initiation of treatment with Campral®. YES NO
2. Has other active substance abuse been ruled out? YES NO
3. If the physician named above, verifying the definitive treatment program, is not a psychiatrist, please provide the name and title of the mental health professional or certified addiction specialist who will be overseeing the treatment. Mark as 'N/A' if no information is available and cannot be provided.

4. Has the recipient been evaluated to rule out pregnancy? YES NO

5. Has the recipient been evaluated to rule out significant renal disease? YES NO

6. Provide details of the treatment program. This should include the name of the treating mental health professional or certified addiction specialist, the recipient's counseling schedule, and the name of the clinic or program, if applicable. The treatment program must be under the supervision of a mental health professional or certified addiction specialist. Alcoholics' Anonymous (AA) is not sufficient alone. Mark as 'N/A' if no information is available and cannot be provided.

7. Extensions of authorization require a detailed update on compliance with counseling and medication.

8. Additional comments: _____

Submit requests to: First Health Services, MAP Department, 4300 Cox Road, Glen Allen, VA 23060
 Fax: 888-603-7696 Phone: 877-864-9014
 This form is available at www.michigan.fhsc.com -> Providers -> Forms