Michigan Department of Health and Human Services (MDHHS)
Prior Authorization Request
Verification of Definitive Treatment Program – Alcohol Abuse Treatment

All information on this form must be addressed. Incomplete forms will be returned 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 MDHHS physician review until completed.

Beneficiary Information

LAST NAME: **FIRST NAME:**

MEDICAID NUMBER: **DATE OF BIRTH:** – –

GENDER: **MALE** ☐ **FEMALE** ☐

Prescriber Information

LAST NAME: **FIRST NAME:**

PLEASE SELECT ONE: ☐ MD ☐ PA ☐ NP ☐ DO ☐ DDS ☐ **OTHER:**

NPI NUMBER: **SPECIALTY:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

Person Completing Form

LAST NAME: **FIRST NAME:**

TITLE:

PHONE NUMBER: – – **FAX NUMBER:** – – –

DATE: **REQUESTED START DATE:**

Pharmacy

NAME:

PHONE NUMBER: – – **FAX NUMBER:** – – –

Medication	Dose	Duration of Tx
Campral® (acamprosate)		

Please address and/or 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:

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.

7. Extensions of authorization require a detailed update on compliance with counseling and medication.
8. Additional comments:

Submit requests to:
Magellan Medicaid Administration
11013 W Broad Street Suite 500, Glen Allen, VA 23060
Fax: 888-603-7696 Phone: 877-864-9014
This form is available at michigan.fhsc.com → Providers → Forms

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