



Date of Request: \_\_\_\_\_

**Sterling Retiree Rx Prior Authorization Form**

**CAMPRAL (Acamprosate)**

**Coverage Criteria / Required Medical Information:**

- A. Clinical diagnosis of alcohol dependence; **and**
- B. Clinical evidence indicating that the patient will be abstinent at least 5 days prior to treatment initiation; **and**
- C. A trial of naltrexone (oral/injectable) has been attempted, at clinically significant dosage and duration **or** therapy is documented to be clinically inappropriate (hepatic insufficiency, chronic pain medication use); **and**
- D. Medication administration should be part of a comprehensive psychosocial treatment program.

**Coverage Duration:** 6 Months

**Exclusion Criteria:** Renal failure

**Member Information**

Name				
Enrollment/Card-holder ID Number				
Group/Plan		Male		Female
Date of Birth		Age		Weight in Kg
Street Address				
City		State		Zip

**Physician Information**

Name				
Agent		Contact Name		
Specialty/Office				
Clinic Name				
Street Address				
City		State		Zip
Phone		Fax		

**Requested Drug**

CAMPRAL	Reason for Request	
Condition/Diagnosis Related		

**Clinical Drug/Lab History Pertinent to Request**

Labs: Baseline/Ongoing		Strength/Dosage		
Formulary Alternative(s) Attempted?		Yes:		No:
Please List Alternative Formulary Drugs				

Comments	
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Physician Signature: \_\_\_\_\_ Fax Form to 1-866-481-3704