Medicated Assisted Treatment Program-Vivitrol

The Blair County SCA has developed a process to incorporate Vivitrol medicated assistance pharmacology intervention into the continuum of drug and alcohol treatment services. The addition of Vivitrol as a medication intervention has shown to improve engagement in treatment and reduce cravings. The medication is an adjunctive to treatment and not a standalone program. Persons identified at the time of assessment, admission to treatment or during their continuum of treatment as being a potential candidate for this medication, can be evaluated for funding through the Blair SCA. Individuals must meet the residency and liability criteria for Blair County funding.

The Goals of the Vivitrol Program are as follows:

- Educate local physicians, medical providers, drug and alcohol treatment specialists, criminal justice and other professions regarding the benefits of medication assisted treatment and the recovery oriented system of care;
- As appropriate and applicable, involve individual's family/support members in the treatment process; and
- Link individuals with community agencies/organizations that provide service, such as employment, housing, medical care, mental health service, etc.

Vivitrol Program Procedures

The procedures will describe the components of the program. Procedures will be developed to ensure all components are implemented in the vivitrol program.

Referral Procedure for Services and Target Population:
At any time during the continuum of case management through treatment, an individual can be identified as being a potential candidate.

Target population:
The following is population may be eligible to be evaluated for this service:

Under 18 (with parent and physician approval)
18 years and older
Male or Female
Alcohol Dependent
Opiate Dependent: Must be opiate free for 7-14 days prior to starting the medication.
Blair County Resident

Physician physical examine are part of the evaluation of candidates for this program.

Community Based Referral Procedure:
Referrals can come from anyone or agency in the community. The referral may contact the SCA or designee to initiate the referral for this service. The SCA/designee will gather initial information to include funding information and current treatment engagement. The SCA/designee will discuss the eligibility to be evaluated for the service and funding of this

intervention. If the individual is not currently in treatment the SCA/designee will transfer the call to the case management for screening and scheduling of an assessment appointment. If an agency is referring an individual, a release of information must be provided in order for the SCA to discuss the individual's case with the referral source.

The SCA/designee will review the funding levels for this service. If the individual is uninsured, a medical assistance application will be completed with the individual. If SCA funding is required, the SCA/designee will identify funding for the service and if available provide authorization for the service.

The referral source (community agency/prison) will submit the Blair County-Vivitrol Referral form **Attachment A (Community)** and signed release of information for the SCA to provide information to the provider.
If the person is uninsured or underinsured, the SCA/designee will complete the Benefit Limitations form **(Attachment C)** at the time of the first appointment.

All services will be authorized monthly if SCA funded. Confirmation of treatment is received monthly.

Prison Based Referral Procedures:
Referrals from the prison will be processed through BDAP Case Management unit. The prison/Adult Probation office can identify an inmate to be evaluated for the in prison Vivitrol Project. The Referral source will complete the Blair County Prison –Vivitrol Referral form **(Attachment B-Prison)**. The Case Management Supervisor will process the referral and schedule a screening and assessment for the individual. Once the Case Manager has completed the screening/assessment, medical assistance packet and educated the inmate on the medicated assisted treatment, the Case Manager will process the request through the medical department of the prison. The nurse will process the request, schedule the individual for an appointment with the physician, complete their required paperwork and make a determination on the appropriateness of the inmate for the medication. If approved, the individual will be scheduled to be provided 1-2 shots prior to release from the prison. The case manager will make arrangements for treatment and a community referral to the Vivitrol project **(Attachment A Community)** prior to release from prison.

Waiting List:
If at the time of contact with the SCA the funding is not available, the individual will be placed on a waiting list.

Program Components:
The Blair county SCA has developed a process to incorporate Vivitrol medicated assistance pharmacology intervention into the continuum of drug and alcohol treatment services. The addition of Vivitrol as a medication intervention has shown to improve engagement in treatment and reduce cravings. The medication is an adjunctive to treatment and not a standalone program. Persons identified at the time of assessment, admission to treatment or during their continuum of treatment as being a potential candidate for this medication, can be evaluated for funding through

the Blair SCA. Individuals must meet the residency and liability criteria for Blair County funding.

Blair Drug and Alcohol Partnership (BDAP) will be the point of contact to determine SCA funding and authorization for this service for the uninsured/underinsured. The review process for the case by BDAP staff will include receipt of all required paperwork and confirmation from the treatment facility (with confidentiality release) of the individual's current participation in treatment. Once a case is reviewed, BDAP will provide authorization for the service within funding guidelines. Monthly data, monitoring and authorization will be provided to BDAP. Individuals participating in the program are required to be engaged in the assessed level of care throughout the course Vivitrol injections. Individuals will be assessed for non-treatment needs and offered resource or intensive case management services when meeting the criteria for those services.

Program Documentation Requirements:
At time of each first appointment the following forms are required to be completed:

Vivitrol Benefit Limitation Form **(attachment C)** if SCA funded;
Vivitrol instruction sheet **(attachment D)**:
Vivitrol Follow up Sheet (if received an injection at another site **(attachment E)**
Risk of Overdose Notification **(attachment F)**
Vivitrol Authorization Form **(attachment G)** if SCA funded
Release of Information (ROI) as needed per each case **(attachment H)**.

Subsequent Appointments:
Vivitrol Follow up Form Attachment 4 –every appointment
Review ROI for current timeframes
Risk of Overdose Notification-Review risk again at the second appointment

Program Case Management Coordination of Care:
At the time of the first appointment
All Vivitrol patients will be seen by a case manager to review the Vivitrol instruction sheet, Risk of Overdose form, assist with medical assistance/funding issues, coordinate SUD treatment and any other non-treatments.

Subsequent Appointments:
Following the first and second injections the patient will be seen on an as needed basis, with a minimal check-in with a case manager every third injection. All patients are made aware a case manager is available upon the request of the patient.

Payment of services
The SCA has identified the following funding resources for this service:
Department of Drug and Alcohol Program State and Federal Alcohol and Drug Block grant
Department of Public Welfare: Behavioral Health Special Initiative and ACT 152
Pennsylvania Commission on Crime and Delinquency Funds

With this signature, I agree to release my information to the secondary contact, confirm future appointments, and to release my information to the counselor listed below.

*Signature: _____ *Date: _____

Medication Assisted Treatment Patient Demographic Sheet
Vivitrol Referrals for Positive Recovery Solutions
FAX to: (724) 249-2825 / Phone: (412) 660-7064

*County of Referral _____

*Patient Name: _____ *Sex: M or F

*DOB _____ *SS/I: _____ *Valid Phone Number: _____

*Address: _____
City State Zip Code

*Drug of choice: _____

*Outpatient Drug & Alcohol Location: _____

*Name of Vivitrol Coordinator / Lead Therapist / Lead Counselor at Location: _____

*Phone Number / Email For Vivitrol Lead at Location: _____

*Patients Counselor Name: _____ *Phone Number: _____

*Person making the referral: *Email/Phone // _____

*Insurance: Y or N (Attach copy of insurance caRI)

*Primary Insurance Company: _____ *ID/Group4 _____

Secondary Insurance Company: _____ ID/Group *4* _____

*Patients Secondary Emergency Contact Name: _____

*Relationship to Patient: _____ *Phone Number: _____

Note(s): _____

_____

Positive Recovery Solutions
Supplemental Form

Participant Name: _____

Participant Date of Birth: _____

Coordinator Name:_____

Coordinator Phone/Extension: _____

Location to be scheduled: _____

Date of last use of substance/alcohol: _____

Participant received Vivitrol in the past? Yes No

Participant received Revia/Naltrexone in the past? Yes No

Date of last injection: _____

Pharmacy Information: _____

Notes:

Revised: 7/13/2020

BLAIR DRUG & ALCOHOL PARTNERSHIPS
Empowering Healthy Lifestyles

Blair County Prison
Vivitrol Referral

Date: _____

Patient Name: _____

DOB: _____ SS# _____ Drug of Choice(s) _____

Potential Release Date: _____ Parole Officer: _____ County _____ State _____

Home Address: _____
City State Zip

Phone: _____ Cell Phone: _____ Email: _____

Gender: _____ Drug of Choice(s) _____ OPIATE USE: Yes ☐ No ☐ Overdose Survivor: Yes ☐ No ☐

Insurance: ☐ Yes ☐ No

Primary Insurance Company: _____ ID/Group# _____

Secondary Insurance Company: _____ ID/Group# _____

Policy Holder: _____
Name Relationship Phone Number

Has patient applied for Medical Assistance? ☐ Yes ☐ No ☐ recently applied, awaiting result

Notes: _____

_____

_____

_____

This individual has been recommended by Blair County Prison staff as a potential candidate for Medicated Assisted Treatment, specifically Vivitrol.

Vivitrol Policy-Attachment B- Prison Referral Form 7-1-2020

BLAIR DRUG & ALCOHOL PARTNERSHIPS

Vivitrol Benefit Limitation Form

Individual's Name _____ **SS#** _____

Please Check Agency who is requesting the service:

Referring Agency: _____

Referring Counselor_____ _____

Phone # _____

Fax #_____

Preliminary Diagnosis_____ _____

Insurance Information
_____The individual does not have insurance
_____ Insurance Info:

InsuranceCompany_____ID#_____Group#_____

Treatment Verification:
____Individual is currently active in treatment at_____

____Individual is scheduled for a drug and alcohol assessment on_____

I have been educated on Vivitrol and risk associated with the medication to include high risks behaviors that can result in overdose. I have been made aware that the payment for Vivitrol medicated assisted treatment is limited. I further understand to be eligible for this assistance; I agree to follow the recommendations for drug and alcohol treatment, self-help groups, or other recovery supports as recommended. I understand I must complete a medical assistance application process prior to the next injection and provide proof of applying.

Signature of the Individual _____**Date** _____

FAX Form to: Blair Drug and Alcohol Partnerships: 814-381-0922

To Be Completed by Blair Drug and Alcohol Partnerships: Services **cannot** be provided unless the individual has signed the above statement.

Specialty Court Participant: __Y___N If yes which court: ___Div___IP____Reentry____DUI___Family

Authorization for Service:_____Date:_____

BLAIR DRUG & ALCOHOL PARTNERSHIPS
Empowering Healthy Lifestyles

Vivitrol Instruction Sheet

You and your provider have decided that Vivitrol is a beneficial therapy for you to support the recovery process and is not a substitute to Drug and Alcohol Therapy. This form will provide you with information and instructions on what to do should you experience any adverse effects or allergic reaction.

Symptoms to watch for and seek immediate medical attention for include:
(If immediate attention is needed, please call 911 or go to the nearest ER)

- Skin rash
- Swelling of face, eyes, mouth or tongue
- Trouble breathing or wheezing
- Chest pain
- Feeling dizzy or faint
- Increasing depressive symptoms
- Thoughts of suicide

Symptoms to watch for and report to your health care provider include:

- Nausea
- Tiredness
- Headache
- Dizziness
- Vomiting
- Decreased appetite
- Painful joints
- Muscle cramps
- Cold symptoms
- Trouble sleeping
- Toothache

Symptoms to watch for at the injection site include:

- Pain
- Large area of swelling
- Blisters
- A dark scab
- The area feels hard
- Lumps
- An open wound

WARNING: If you are on Vivitrol and discontinue this medication, you should be aware that returning to a level of drug or alcohol use could result in a life-threatening overdose.

Notify your provider about any reaction at an injection site that concerns you, gets worse over time or does not get better by 2 weeks after the injection.
Please notify the office at 814-381-0921 with any questions or concerns.

Client Printed name_____

Client Signature: _____ Date: _____

Copy provided to client _____ yes _____ no

BLAIR DRUG & ALCOHOL PARTNERSHIPS
Expanding Healthy Lifestyles

Patient Name: _____
Date: _____
Would you like to speak to a Case Manager?
____Yes ____No

Vivitrol Follow up

1. Have you experienced adverse reactions/any side effects to the Vivitrol injection? _____Yes _____No
   If yes, what effects: ie; nausea, vomiting, diarrhea, headaches, rash/hives, difficulty breathing, abdominal discomfort or swelling at injection site

   Other_____

2. Are you having cravings and urges? 0 = Not at all 10 = Very Strong (Circle One)

   0 1 2 3 4 5 6 7 8 9 10

   If so, in which week did this occur?
   Week 1 ____ Week 2____ Week 3____ Week 4____

3. Have you noticed any other "addictive behaviors" (shopping, shoplifting, gambling, eating, sex, etc)?
   ___No _____Yes If yes_____

4. Have you used any drugs or alcohol since your last visit (prescribed or not) _____Yes _____No
   Identify use:_____

5. Have you started taking any new or stopped taking any medications since your last visit?
   _____

6. Are you attending services/support groups? ____Yes ____No

   _____Drug & Alcohol treatment _____AA/NA or other self-help groups _____Peer Supports

   _____Mental Health Treatment _____Treatment Courts _____None _____Other_____

7. Have you been incarcerated since your last shot? Yes No Date _____
   Why: _____

8. What is the longest time you ever had clean and sober outside of a 'structured environment' (jail, tx facility)?_____

   What is your current recovery time? _____

9. What do you like most about Vivitrol?

10. Would you recommend Vivitrol to others? _____Yes _____No

RISK OF OVERDOSE NOTIFICATION

What is the most important information I should know about VIVITROL?

VIVITROL can cause serious side effects, including:

1. Risk of opioid overdose.

You can accidentally overdose in two ways:

- VIVITROL blocks the effects of opioids, such as heroin or opioid pain medicines (**Hydrocodone-Vicoden,Lortab, Norco, Codeine, Morphine, OxyContin, Percocet, Roxicet, Opana, Suboxone, Methadone, Heroin**).
  Do not take large amounts of opioids, including opioid-containing medicines, such as heroin or prescription pain pills, to try to overcome the opioid-blocking effects of VIVITROL. This can lead to serious injury, coma, or death.
- After you receive a dose of VIVITROL, its blocking effect slowly decreases and completely goes away over time. If you have used opioid street drugs or opioid-containing medicines in the past, using opioids in amounts that you used before treatment with VIVITROL can lead to overdose and death. You may also be more sensitive to the effects of **lower** amounts of opioids:

  - after you have gone through detoxification
  - when your next VIVITROL dose is due
  - if you miss a dose of VIVITROL
  - after you stop VIVITROL treatment

  It is important that you tell your family and the people closest to you of this increased sensitivity to opioids and the risk of overdose.

You or someone close to you should get emergency medical help right away if you:

- have trouble breathing
- become very drowsy with slowed breathing
- have slow, shallow breathing (little chest movement with breathing)
- feel faint, very dizzy, confused, or have unusual symptoms

I have read and understand the above precautions and given a 'medical alert' wallet card.

Printed Name_____

Signature_____Date_____

Witness_____Date_____

Blair Drug and Alcohol Vivitrol Service Authorization Form

Person Receiving Services:_____ **DOB:**_____

_____**Residential**

_____**Community Based Vivitrol Service**

_____**Prison Based Vivitrol Service**

Currently in Treatment with:_____

Vivitrol Provider:_____

_____ **Initial Physician Assessment** **Date of Service:**_____

_____**Follow-up Physician Assessment** **Date of Service:**_____

_____**Urine Drug Test** **Date of Service:**_____

_____**Medication Injection** **Date of injection:**_____

_____**Lab Corp** _____**Prison Lab** **Timeframe (3wk):**_____

_____**Cost of Injection:**_____

Name and Phone Number of Person completing the form: (Please Print)

_____

_____**Bessie Paperwork Completed on medication reimbursement requests (please check if applicable)**

Fax to Blair County Drug and Alcohol: 814-381-0922. Any questions please contact Executive Director or Assistant Director at 814-381-0921

Blair Drug and Alcohol Partnerships Use Only:

Funding Source:

PCCD: Dept 9: _____ **DUI:** _____ **Non DUI**

Base: Dept 3: _____**Specify fund**

Other Funding:_____ **Specify Funds**

OUD Patient: ____**Y**_____**N**

BLAIR COUNTY DRUG AND ALCOHOL PROGRAM, INC. CONFIDENTIALITY

AUTHORIZATION TO RELEASE INFORMATION

Individual Name: _____

I hereby authorize:

_____
Name of Organization, Person, or Title

At: _____
Address

to release the following information to:

_____
Name of Organization, Person, or Title

At: _____
Address

The Following information pertaining to MYSELF.

THE INFORMATION WHICH MAY BE RELEASED IS LIMITED STRICTLY TO THE FOLLOWING:

( ) ASAM Summary Sheet	( ) Attendance
( ) Psychosocial/Diagnostic Summary	( ) Progress on Objectives
( ) Emergency Contact	( ) Legal System (Type of program, summary of progress,
( ) Preliminary Diagnosis	Type/Frequency of relapse and prognosis
( ) Physical Description	( ) Liability Information

Specify date, event, or condition ONLY if consent expires sooner than 1 year; otherwise specify NA: _____

- I understand that this authorization may be cancelled at any time by a verbal or written request unless I have been mandated into treatment as a result of a criminal proceeding. Information may have been previously released prior to the cancellation.
- I understand that I may refuse to sign this authorization; my refusal will not prevent me from receiving services; my refusal will prevent the treatment providers from sharing information that may be beneficial to my treatment.
- I have read and understand the intent of this authorization.
- I have been offered and ☐ accepted ☐ refused a copy of this form.

_____ _____
Individual's Signature Witness to Signature

_____ _____
Date Date

A copy of the Authorization shall be deemed valid as original. *To be valid, this Authorization must be signed and dated.*

PROHIBITION OF REDISCLOSURE: The information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations prohibit you from making any further disclosures of this information except with the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general release of medical or other information is NOT sufficient for this purpose. Federal rules do not allow any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.