

Specialty Pharmacy Services

## **Vivitrol Request Form**

Fax Referral To: (847) 427-7975

Phone: (800) 373-1406		Date:	Needs by I	Date:	
Ship to: Office Other:					
PATIENT INFORMATION PRESCRIBER INFORMATION					
	lowing or send patient demograp	phic sheet) Prescribe	Prescriber's Name:		
Patient Name:	0		License #:	UPIN:	
Address:			DEA #:	NPI #:	
City, State, Zip:			Hospital:	<del></del>	
Home Dhene.			Address:		
Alternate Phone:			State 7in:		
SS #: Primary Language:			Phone:	Fax:	
Date of Birth: Gender:		Conta	act Person:	Phone:	
INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription drug card)					
Prescription Card		ID#:	BIN: PCN		
Primary Insurance		ID#:	Name of Insurer:	Phone:	
Secondary Insurance		ID#:	Name of Insurer:	Phone:	
				Thone.	<u> </u>
STATEMENT OF MEDICAL NECESSITY  Diagnosis: Other Clinical Information:					
Alcohol Dependenc	Δ.				□мо
F10.20 Other and unspecified alcohol dependence unspecified drinking behavior			<ul> <li>Is patient currently receiving opioid analgesics?  ☐ Yes ☐ No</li> <li>Is patient currently opioid dependent? ☐ Yes ☐ No</li> </ul>		
F10.20 Other and unspecified alcohol dependence continuous drinking behavior			<ul><li>Is patient currently opioid deposit</li><li>Is patient in opioid withdrawl?</li></ul>		
_				<del></del>	
F10.20 Other and unspecified alcohol dependence episodic drinking behavior  F10.21 Other and unspecified alcohol dependence in remission			• Does patient have liver disease?		
1 10.21 Outer and unspectfied alcohol dependence in fellission			• Allergies:		
O-:-:1 D1			• Weight: kg/lbs		
Opioid Dependence			• Comments:		
F11.20 Opioid type dependence unspecified use			Concomitant Medications:		
F11.20 Opioid type dependence continuous use			Patient has had prior detoxification and/or residemtial treatment for alcohol dependence, indicating a lack of success of traditional treatment approaches and		
F11.20 Opioid type dependence episodic use			need for a long-lasting medication.		
F11.21 Opioid type dependence in remission			Patient has a history of non-compliance with other treatments and/or medications.		
Combination of opioid type drug with any other drug dependence (fifth			Patient does not have a family or social support system that will assist in their		
aigii requirea)			daily taking of oral naltexone.		
			Patient has a co-occuring mental health condition that impacts their decision making capabilities to be compliant with treatment recommendations.		
• Date of Diagnosis.					
• Specialty Pharmacy to coordinate injection administration/home health nurse visit as necessary. ☐ Yes ☐ No					
*Agency of choice:					
• Injection administration/home health nurse visit coordination is not necessary.  Date of treatment start:					
Reason: MD office to administer to patient Injection administration/home health nursing already coordinated					
PRESCRIPTION INFORMATION					
MEDICATION	STRENGTH		ECTIONS	QUANTITY	REFILLS
1,122210111101,	51121(0111			One 380mg vial Kit	1121122
☐ Vivitral® ☐ 380mg vial Kit ☐ Administer			ntmomana and and reasons A recole	(includes supplies)*	
		_	ntramuscularly every 4 weeks	see below	
	(jor iniramusemar injection)	or once a month		Other:	
Ancillary Supplies and Kits Provided As Needed for Administration * Vivitrol® Kit includes:					
Vial of Vivitrol ® microspheres					
			Vial of diluent		
			One 20G ½" preparation needle		
			Two 20G 1 & ½" administer needles		
TWO ZOO T & 72 autilitister fleedies					
X X					
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)					