Date: _____	**Vivitrol Referral Form**	

PATIENT INFORMATION:					
Last Name:	First Name:		Home Phone:	Mobile:	
Home Address:			City:	State:	Zip:
Date of Birth:	Gender:	Weight:	Height:	Language:	
ICD Code:	Diagnosis:			Allergies:	
Caregiver Name:		Relationship:		Number:	
Emergency Contact Name:		Relationship:		Number:	

HEATLHCARE PROVIDER INFORMATION				
Practice Name:	Dr Name:	Phone:	Fax	
Address:		City:	State:	Zip:
Shipping Address:		City:	State:	Zip:
NPI:	DEA:	License:	UPIN:	
Nurse/Key Contact:		Number:	Email:	

INSURANCE INFORMATION			
Medical Insurance Name:		Prescription Insurance Name:	
Contact Number:		Contact Number:	
Cardholder Name:	DOB:	Cardholder:	DOB:
ID Number:		ID Number:	PCN:
Group Number:		Group Number:	BIN:
☐ Attach a Copy of Both Sides of the Patient's Insurance Card (s)			

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ VIVITROL (naltrexone for extended release injection solution)	☐ 380 mg	☐ Intramuscularly (IM) every 28 days ☐ Intramuscularly (IM) every _____ days		
☐				
☐ Supplies needed to administer the therapy (needles, syringes, sterile water, etc)		☐ Send quantity sufficient for medication days supply		

CLINICAL

Has the patient been on therapy before? ☐ No ☐ Yes: Date of last dose:_____ | Will the patient abstain from alcohol or drugs? ☐ Yes ☐ No

Alcohol Dependence: ☐ Yes ☐ No ☐ N/A **Diagnosis Code:** _____
Has patient tried & failed oral naltrexone? ☐ Yes ☐ No Patient actively consuming alcohol at time of treatment initiation? ☐ Yes ☐ No

Opioid Dependence: ☐ Yes ☐ No ☐ N/A **Diagnosis Code**: _____ Has patient tried & failed oral buprenorphine/naloxone? ☐ Yes ☐ No
Is there documentation patient has been opioid free for at least 7 days prior treatment initiation? ☐ Yes ☐ No

LFT WNL: ☐ Yes ☐ No | Will treatment be part of a comprehensive management program that includes psychosocial support? ☐ Yes ☐ No

Ship To: ☐ Physician's Office ☐ Other:_____ **Date Needed:** _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____

☐ Product substitution permitted ☐ Dispense as written ***Stamp signature not allowed, physician signature required *** Verbal Readback ☐ Yes ☐ No