Vivitrol Enrollment Form

InfuCare Rx

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Website: www.InfuCareRx.com

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Name:			Prescribing Practitioner:		NPI:
Address:			Address:		
City:	State/Zip:		City		State/Zip
Telephone:	DOB:	M ☐ F ☐	Office:		DEA:
Language Preference:	Wt:	Ht:	Contact:	Phone:	Fax:

PRIMARY INSURANCE INFORMATION			
Member Name:	M ☐ F ☐	DOB:	
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:	New ☐ Refill ☐	Ship by:

PLEASE FAX COPY OF: ☐ PRESCRIPTION FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

PRESCRIPTION

Drug		Directions	Quantity	Refills
Vivitrol™	☐ 380mg	Inject 380mg intramuscularly every 4 weeks (Qty 1)		
☐				

DIAGNOSIS AND CLINICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

Diagnosis and ICD10: ☐ F10.20 Alcohol dependence, uncomplicated ☐ F10.21 Alcohol dependence, in remission
☐ F11.20 Opioid dependence, uncomplicate ☐ F11.21 Opioid dependence, in remission
☐ F19.20 Other psychoactive substance dependence, uncomplicated ☐ Other:_____

Prior meds failed: ☐ Naltrexone ☐ Other:_____

Is patient currently receiving opioid analgesics? ☐ Yes ☐ No

Is patient currently opioid dependent? ☐ Yes ☐ No

Is patient in opioid withdrawal? ☐ Yes ☐ No

Does patient have liver disease? ☐ Yes ☐ No

Is the patient : ☐ Inpatient ☐ Outpatient

Has the patient had a negative drug screen? ☐ Yes ☐ No Date of drug screen:_____

Documentation that the client is receiving Counseling ☐ Yes ☐ No, and/or Treatment ☐ Yes ☐ No

Current Medications:

Additional Clinical Information:

Allergies:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner: **Date:**