InfuCare Rx

Vivitrol™ Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881

✂ Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

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

Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____
Current Medications: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ 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: _____
Documentation that the client is receiving Counseling ☐ Yes ☐ No
and/or Treatment ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	Quantity	Refills
Vivitrol™	☐ 380mg	☐ Inject 380mg intramuscularly every 4 weeks (Qty 1)		
Other:				

ADDITIONAL COMMENTS

Prescriber Signature: _____ **Date:** _____

✂

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