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:** ______________

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by faxing back to the originator.