



# Vivitrol® Enrollment Form

Fax Referral Form To: 1-781-805-8245  
 Specialty Pharmacy Phone: 1-844-319-7588

Please fill out the following 6 areas to submit a referral:

**1 PATIENT INFORMATION**

Patient Name		Date of Birth
Address		Primary Phone
City	State	Alternate Phone
ZIP	Gender Male Female	Email
Primary Language		

**2 PRESCRIBER INFORMATION**

Prescriber's Name	License #
DEA #	NPI
Group or Hospital Name	Contact Person
Address	Phone
City, State, ZIP	Fax

**3 INSURANCE INFORMATION**

Please fax copy of prescription and insurance cards with applicable pre-authorization approvals with this form, if available

**4 DIAGNOSIS AND CLINICAL INFORMATION**

Needs by Date: \_\_\_\_\_ Ship to: Medical Office OR Other: \_\_\_\_\_  
 (ALL orders will be shipped to medical facility listed unless otherwise indicated)

**Alcohol Dependence**

- 303.90 - Other and unspecified alcohol dependence unspecified drinking behavior
- 303.91 - Other and unspecified alcohol dependence continuous drinking behavior
- 303.92 - Other and unspecified alcohol dependence episodic drinking behavior
- 303.93 - Other and unspecified alcohol dependence dependence in remission

**Opioid Dependence**

- 304.00 - Opioid type dependence unspecified use
- 304.01 - Opioid type dependence continuous use
- 304.02 - Opioid type dependence episodic use
- 304.03 - Opioid type dependence in remission
- 304.7\_\_\_ - Combination of opioid type drug with any other drug dependence (fifth digit required)

Other: \_\_\_\_\_  
 ICD-10 Code and Description: \_\_\_\_\_

Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ kg/lbs Allergies: \_\_\_\_\_

**5 PRESCRIPTION INFORMATION**

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Vivitrol®	<input type="checkbox"/> 380mg vial Kit (for intramuscular injection)	<input type="checkbox"/> Administer 380mg intramuscularly every 4 weeks (28 days) <input type="checkbox"/> Other: _____	<input type="checkbox"/> One 380mg vial Kit (includes supplies)* - see below <input type="checkbox"/> Other	
<input type="checkbox"/> _____				

\*Vivitrol® Kit Includes: Vial of Vivitrol microspheres, Vial of diluent, One 20G 1/2" preparation needle, Two 20G 1 & 1/2" administration needles

**6**

**STAMP SIGNATURE NOT ALLOWED**  
 PHYSICIAN SIGNATURE REQUIRED

X \_\_\_\_\_ X \_\_\_\_\_  
 Product Substitution Permitted Date Dispense as Written (DAW) Date