Prescription & Enrollment Form

Vivitrol®

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name ______
Last name ______ Middle initial ______
Date of birth ______ ❑ Male ❑ Female Last 4 digits of SSN ______
Street address ______ Apt # ______
City ______ State ______ Zip ______
Parent/guardian (if applicable) ______
Cell phone ______
Other phone ______
E-mail address ______
Patient's primary language: ❑ English ❑ Other
If other, please specify ______

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company ______
Phone ______
Insured's name ______
Insured's employer ______
Relationship to patient ______
Identification # ______
Policy/group # ______
Prescription card: ❑ Yes ❑ No If yes, carrier ______
Policy # ______
Group # ______
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed by ______
Prescriber's first name ______ Last name ______
Prescriber's title ______
If NP or PA, under direction of Dr. ______
Office contact and title ______
Office contact e-mail ______
Office/clinic/institution name ______
Clinic/hospital affiliation ______
Street address ______ Suite # ______
City ______ State ______ Zip ______
Phone ______ Fax ______
NPI # ______ License # ______
Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic
Clinic location ______

3 CLINICAL INFORMATION

Primary ICD-10 code: ______
Has the patient been on therapy before: ❑ Yes Date of last dose ______ ❑ No
Please provide clinical documentation of response: ______
If the diagnosis is alcohol or drug dependence, will the patient abstain from using alcohol or drugs? ❑ Yes ❑ No
Will treatment be part of a comprehensive management program that includes psychosocial support? ❑ Yes ❑ No
Does the patient have any of the following: ❑ Yes ❑ No
- Receiving opioid analgesics
- With current physiologic opioid dependence
- Is in acute opiate withdrawl
- Failed the naloxone challenge test or has a positive urine screen for opioids
- Who has acute hepatitis/liver failure

Please provide detailed information of pharmacologic and non-pharmacologic therapies used:

Drug or Non-pharmalogical Therapy	Date	Dose Range and/or Response

❑ NKDA ❑ Known drug allergies ______
Concurrent meds ______

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Vivitrol® (naltrexone)	380mg single use carton	❑ Inject 380mg IM every 28 days ❑ Inject 380mg IM every ______ days	Dispense: ❑ 28-day supply ❑ 84-day supply ❑ Other ______ Refills ______
❑ Prescriber please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed for administration			Send quantity sufficient for medication days supply

I hereby authorize Accredo to contact my prescribing provider to coordinate the delivery, receipt and storage of my Vivitrol prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

______
Patient authorization

Further patient copay responsibility over $50 may result in an outreach to the patient to obtain authorization.

By signing below, I certify that the above therapy is medically necessary and my office will accept shipment on behalf of patient for administration in office. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**) **PHYSICIAN SIGNATURE REQUIRED**

______ Date ______ Dispense as written ______ Date ______ Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to your drug therapy team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions.
Go to MyAccredoPatients.com to log in or get started.

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