Please fax both pages of completed form to your drug therapy team at 888.302.1028.

To reach your team, call toll-free 866.808.0967.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Vivitrol®

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name _____ Last name _____ Middle initial _____

❑ Male ❑ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

❑ OK to leave message with alternate caregiver/contact

Patient's primary language: ❑ English ❑ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office contact and title _____

Office contact phone number _____ 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 ❑ Clinic

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 withdrawal • 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 _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

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. as needed to administer the therapy			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.

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.
By signing below, I certify that the above therapy is medically necessary. 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)

SIGN HERE 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.

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