

Los Angeles, CA  
2080 Century Park East  
Suite 710  
Los Angeles, CA 90067



# ORDER FORM VIVITROL®

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION	
Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: Fax:	Email (for updates):

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> Discontinuation Order	

## Prescriber Information

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_

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

Office address \_\_\_\_\_

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

## 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 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

Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Vivitrol® (naltrexone)	380mg single use carton	<input type="checkbox"/> Inject 380mg IM every 28 days <input type="checkbox"/> Inject 380mg IM every _____ days	Dispense: <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> 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

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_