

Princeton / Somerset New Jersey  
49 Veronica Avenue  
Suite 202  
Somerset, NJ 08873

Long Branch  
422 Morris Avenue  
Suite 7  
Long branch, NJ 07740

Marlton  
127 Church Road  
Suite 600  
Marlton, NJ 08053



# 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

New Referral    Referral Renewal    Medication/Order Change    Benefits Verification Only    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 \_\_\_\_\_