Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

ThrIVewell™
INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

ORDER FORM VIVITROL®

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
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
☐ 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

ORDERING PROVIDER

Signature X _____ Date _____ Provider _____

Phone _____ Fax _____