

Center City
1528 Walnut Street
Suite 1205
Philadelphia, PA 19102



King Of Prussia
216 Mall Blvd
Suite#1
King Of Prussia, PA, 19046

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 _____