Fax Referral To:
814-283-2211
www.vsprx.com

Vivitrol Enrollment Form

Ship to:
☐ **Office**
☐ **Care Site**
☐ **Other:**

855-265-8008

PATIENT INFORMATION

*(Complete the following or **send patient demographic***			Prescriber's Name:		
Patient Name:			State License #:	UPIN:	
Address:			DEA #:	NPI #:	
City, State,			Group or Hospital:		
Home Phone:			Address:		
Cell Phone:			City, State Zip:		
Allergies:			Phone:	Fax:	
Date of Birth:		Gender:	Contact Person:	Phone:	

Prescription Card:	ID#:		BIN:		PCN:	Group:	
Primary Insurance:	ID#:		Name of			Phone:	
Secondary	ID#:		Name of			Phone:	

DIAGNOSIS INFORMATION ☐ Alcohol Dependence ☐ Opioid Dependence ☐ Other mental health condition

PRESCRIPTION STATUS ☐ New ☐ Reauthorization ☐ Restart

PRESCRIPTION and PRIOR AUTHORIATION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	FREQUENCY	QUANTITY	REFILLS
☐ **Vivitrol Kit** **(includes medication, diluent, administration supplies)**	☐ **380mg**	**Prescriber to inject contents of one vial intramuscularly**	☐ **every 28 days** ☐ _____	**#1**	

Patient has failed the following oral therapies ☐ Acamprosate ☐ Naltrexone ☐ Disulfiram

Is the patient in eminent danger/at risk if medication is not approved? ☐ Yes ☐ No

Does the patient currently drink alcohol? ☐ Yes ☐ No

Is the patient currently taking any opioids for pain management? ☐ Yes, Specify _____ ☐ No

Has the patient been opioid free for a minimum of 7-10 days prior to therapy initiation? ☐ Yes ☐ No

Does the patient have documentation of a recent urine drug screen? ☐ Yes, Date _____ ☐ No

Is the patient currently in a comprehensive treatment plan that includes psychosocial support? ☐ Yes ☐ No

Has the patient been screened for hepatitis/liver failure? PLEASE ATTACH LAB RESULTS ☐ Yes ☐ No

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

Physician Signature Date	This prescription will be filled generically unless prescriber writes "DAW" in the box to the right	☐