



# Addiction Recovery Enrollment Form

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

Patient Data

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs kg  
 SSN #: XXX-XX-\_\_\_\_ Known Allergies: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Alternate Caregiver Name: \_\_\_\_\_ Phone of Caregiver: \_\_\_\_\_

Ins. Data

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 Policy: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy: \_\_\_\_\_ Group#: \_\_\_\_\_

Diagnosis

F11.20 Opioid Dependence       F10.20 Alcohol Dependence       Other \_\_\_\_\_

Clinical Information

*Please attach clinical notes, lab results, and supportive documentation of behavioral health enrollment to expedite the prior authorization*

Is the patient currently in a comprehensive treatment plan that includes psychosocial support?  Yes  No  
 Has patient tried and tolerated oral Naltrexone?  Yes  No  
 Has the patient been opioid free for a minimum of 7-10 days prior to therapy treatment?  Yes  No  
 Does the patient have documentation of recent urine drug screen and/or blood alcohol screen?  Yes Date: \_\_\_\_\_  No  
 Has the patient been screened for hepatitis/liver failure?  Yes  No  
 Start of Care Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Anticipated Injection Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Prescription

Medication	Directions	Quantity	Refills
Vivitrol Kit 380mg (includes medication, diluent, administration supplies)	Prescriber to inject contents of one vial intramuscularly every 28 days	#1	

After Care Plan

Anticipated date of discharge? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Place of discharge unknown  Yes  No  
 Place of discharge: \_\_\_\_\_ Location: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Injection Services

Value Specialty Pharmacy nurse injection services needed?  Yes  No  
 Place of injection:  Physicians Office  Nurse Coordinated Location  Value Specialty Pharmacy

Is patient new to this therapy:  YES  NO | Ship to:  Patient  Office  Other

Prescriber Data

Prescribers Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Key Contact#: \_\_\_\_\_

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 process.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

fax referral to: **844-812-6227** | phone: **855-265-8008** | **www.vsprx.com**