Addiction Recovery Enrollment Form

VALUE SPECIALTY PHARMACY

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs kg
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
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: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#:_____ NPI: _____
Contact: _____
Phone: _____ Fax: _____
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.