Phone: 417-719-4510
Fax: 417-893-3908
specialty.alpspharmacy.com

Vivitrol

PATIENT INFORMATION

Patient Name: ______________________________
Address: ______________________________
City, State, ZIP: ______________________________
Home Phone: ______________ Alternate Phone: ______________
Caregiver: ______________ Email: ______________
DOB: ______________ Social Security#: ______________
Gender: ☐ Male ☐ Female Comorbidities: ______________
Height: ________ Weight: ________ Allergies: ______________

PRESCRIBER INFORMATION

Prescriber's Name: ______________________________
Address: ______________________________
City, State, ZIP: ______________________________
Phone: ______________ Fax: ______________
NPI: ______________ Tax-ID# : ______________
DEA: ______________________________
Office Contact: ______________ Phone: ______________
Contact Email: ______________________________

INSURANCE INFORMATION

[Please fax a copy of patients' insurance cards (prescription and medical, FRONT and BACK) including any secondary insurance.]

DIAGNOSIS AND CLINICAL INFORMATION **[Please attach separate sheet if needed.]**

Diagnosis and IDC-10 code: ______________________________
Date of Diagnosis: ______________________________

Alcohol Dependence
☐ F10. ______
☐ F10. ______
☐ F10. ______

Opioid Dependence
☐ F11. ______
☐ F11. ______
☐ F11. ______

Other: ______________________________

Previous Drug or Non-pharmalogical Therapy	Date	Dose Range and/or Response
☐ Oral Naltrexone		
☐ Buprenorphine		
☐ Buprenorphine/Naloxone		

Has the patient been on Vivitrol before? ☐ Yes ☐ No
If yes, Date of last dose: ______________

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 the treatment be part of a comprehensive management program that includes psychosocial support? ☐ Yes ☐ No

Does the patient have any of the following:
Receiving opioid analgesics? ☐ Yes ☐ No
Current physiolgic opioid dependence? ☐ Yes ☐ No
Is in acute opiate withdrawl? ☐ Yes ☐ No
Failed the naloxone challenge test? ☐ Yes ☐ No
Has a positive urine screen for opiods? ☐ Yes ☐ No
Has acute hepatitis/liver failure? ☐ Yes ☐ No
Currently pregnant or nursing? ☐ Yes ☐ No

Concurrent Medications: ______________________________
____

Additional Information: ______________________________
____
____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Vivitrol®	☐ 380 mg vial Kit *(for intramuscular injection)*	☐ Inject/Administer 380 mg intramuscularly every 4 weeks ☐ Other: ______________	☐ One 380 mg vial Kit ☐ Other: ______________	

INJECTION TRAINING

☐ To Be Administered by Pharmacist ☐ To Be Administered in MD Office

PRESCRIPTION DELIVERY

☐ Physician's Office ☐ Patient Will Pick Up in Pharmacy Date Issued: ______________ Needs by Date: ______________

PRESCRIBER AUTHORIZATION

I authorize Alps Pharmacy, including it's representatives and subcontractors, to act as my agent to initiate and execute the insurance prior authorization, patient assistance, and nursing programs. If Alps Pharmacy is unable to fulfill this prescription, I authorize Alps Pharmacy to forward this information and data related to the coverage of this prescription to another pharmacy.

Prescriber's Signature: ______________________ Date: __________
PRODUCT SUBSTITUTION PERMITTED

Prescriber's Signature: ______________________ Date: __________
Dispense As Written

CONFIDENTIALITY NOTICE

The information contained in this for is intended only for the use of individual or entity named. It contains confidential information, legally privileged, that may be protected health information under federal and state laws. If you are not the intended recipient, you are hereby notified that any dissemination, copying, or distribution of this communication is strictly prohibited. If you have received this form in error, please notify the sender and immediately destroy this communication.

Disclaimer: Alps can accept only original prescription drug orders from patients, and faxed prescriptions can be accepted only from the prescribing practitioners.