Vivitrol Intake Form

Northborough, MA: **Toll free** (855) 880-1091 **Toll free fax** (844) 265-0265

www.AllCarePlusPharmacy.com

DATE: __________ THERAPY START DATE: _______________ DELIVERY : ☐ PATIENT ☐ OFFICE ☐ OTHER: ______________________________

PATIENT INFORMATION

Patient Name

Address

City, State, Zip

Phone

Social Security

Date of Birth

Gender ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Name

Group/Hospital

Address

City, State, Zip

Phone Fax

DEA/NPI #

Preparer Name/Office Contact

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

Plan Name: ______________________________ **PCN#:** ______________________________

Insurance Phone#: ______________________________ **ID#:** ________________ **Group#:** ________________

BIN#: ______________________________ **Person Code:** ______________________________

CLINICAL INFORMATION

Alcohol Dependence

☐ ICD-10: **F10** ______________

☐ ICD-10: **F10** ______________

☐ ICD-10: **F10** ______________

☐ Other ICD-10: ______________________

Opioid Dependence

☐ ICD-10: **F11** ______________

☐ ICD-10: **F11** ______________

☐ ICD-10: **F11** ______________

☐ Other ICD-10: ______________________

Patient has tried and failed the following medication(s): ______________________________

Patient Allergies: ______________________________

PRESCRIPTION INFORMATION

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Vivitrol ®	380 mg vial	IM q4 weeks or q 1 month	1 vial for a 28 day supply	________

INJECTION PROVIDER INFORMATION

Will Your Office/Facility Be Injecting VIVITROL? (Check ONE)

☐ **Yes**, ALL doses ☐ **No**, I will refer to the Injection Provider/Facility below

Injection Provider Information (Complete if referring to an Injection Provider/Facility other than your own)

Provider Name: ______________________________ Facility Name: ______________________________

Provider Phone #: ______________________________ Staff Contact Name: ______________________________

Provider Fax #: ______________________________ Staff Contact Phone #: ______________________________

Physician Signature: ______________________________ Date: ______________

I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. In no event should the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the Pharmacy of their choice, if AllCare Plus Pharmacy is the Pharmacy of choice, please follow up with a call in, electronic, faxed or mailed prescription to AllCare Plus Pharmacy, 50 Bearfoot Road, Northborough, MA 01532. (Phone) 1 855 880 1091 (Fax) 1 844 265 0265

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