Orsini
Specialty Pharmacy Services

**Phone: (800) 373-1406**

# Vivitrol Request Form

## Fax Referral To: (847) 427-7975

**Date:** _____ **Needs by Date:** _____

**Ship to:** ☐ **Office** ☐ **Other:** _____

### PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

### PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

### INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

**Prescription Card:** Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
**Primary Insurance:** Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
**Secondary Insurance:** Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

### STATEMENT OF MEDICAL NECESSITY

**Diagnosis:**

**Alcohol Dependence**

☐ F10.20 Other and unspecified alcohol dependence unspecified drinking behavior
☐ F10.20 Other and unspecified alcohol dependence continuous drinking behavior
☐ F10.20 Other and unspecified alcohol dependence episodic drinking behavior
☐ F10.21 Other and unspecified alcohol dependence in remission

**Opioid Dependence**

☐ F11.20 Opioid type dependence unspecified use
☐ F11.20 Opioid type dependence continuous use
☐ F11.20 Opioid type dependence episodic use
☐ F11.21 Opioid type dependence in remission
☐ F19.20 Combination of opioid type drug with any other drug dependence *(fifth digit required)*
☐ Other: _____

• Date of Diagnosis: _____

**Other Clinical Information:**

• Is patient currently receiving opioid analgesics? ☐ Yes ☐ No
• Is patient currently opioid dependent? ☐ Yes ☐ No
• Is patient in opioid withdrawl? ☐ Yes ☐ No
• Does patient have liver disease? ☐ Yes ☐ No
• Allergies: _____
• Weight: _____ kg/lbs
• Comments: _____
• Concomitant Medications: _____

☐ Patient has had prior detoxification and/or residemtial treatment for alcohol dependence, indicating a lack of success of traditional treatment approaches and need for a long-lasting medication.
☐ Patient has a history of non-compliance with other treatments and/or medications.
☐ Patient does not have a family or social support system that will assist in their daily taking of oral naltexone.
☐ Patient has a co-occuring mental health condition that impacts their decision making capabilities to be compliant with treatment recommendations.

**Injection Administration/Home Health Coordination:**

• Specialty Pharmacy to coordinate injection administration/home health nurse visit as necessary. ☐ Yes ☐ No
*Agency of choice: _____
• Injection administration/home health nurse visit coordination is not necessary. Date of treatment start: _____
Reason: ☐ MD office to administer to patient ☐ Injection administration/home health nursing already coordinated

### PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ Vivitrol® | ☐ 380mg vial Kit *(for intramuscular injection)* | ☐ Administer 380mg intramuscularly every 4 weeks or once a month | ☐ One 380mg vial Kit *(includes supplies)** *-- see below* ☐ Other: _____ | |
| ☐ | | | | |

*Ancillary Supplies and Kits Provided As Needed for Administration*

*** Vivitrol® Kit includes:**
Vial of Vivitrol ® **microspheres**
Vial of diluent
One 20G ½" preparation needle
Two 20G 1 & ½" administer needles

**X** _____
PRODUCT SUBSTITUTION PERMITTED (Date)

**X** _____
DISPENSE AS WRITTEN (Date)