

VIVITROL® REFERRAL FORM

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821

FAX: 877-526-8823

Start Date

	Please fay front	and back copy of the in	surance card (Pr	Ship To: Office rescription and Medical)	e 🗌 Other
1. Patient Information:				Soc. Sec. #	
Patient:		Wale / Female	DOB	500. 500. #	
Address:	Street	City		State Zip	
		<u></u>	•	mber:	
			Heigh	nt: Weight:	
2. Clinical Information: Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior š±°¤«®¶§°¾a					
ICD-10 Diagnosis: Alcohol Dependence			Opioid Dependence		
□ F10.229 Acute alcoholic intoxication in alcoholism un specified drinking behavior □ F10.20 Acute alcoholic intoxication in alcoholism continuous drinking			☐ F11.20 Opioid type dependence unspecified use ☐ F11.20 Opioid type dependence continuous use		
behavior ☐ F10.20 Other and unspecified alcohol dependence unspecified drinking			□ F11.20 C	Opioid type dependence episodic	use
behavior					
☐ F10.20 Other and unspecified alcohol dependence continuous drinking behavior				pioid type dependence in remis	ssion
☐ F10.20 Other and unspecified alcohol dependence episodic drinking			□ F11.2	(fifth digit required)	
behavior ☐ F10.21 Other and	unspecified alcohol dependence in	remission	□ Other		
	·				
□ Other					
3. Prescription Informatio		ed a medication not list			D. CH.
3. Prescription Informatio	n: If you nee	ed a medication not lis		ct us Quantity	Refills
•			ns		Refills
Medication	Strength	Directio	ns	Quantity	Refills
Medication	Strength	Directio	ns	Quantity	Refills
Medication	Strength	Directio	ns	Quantity	Refills
Medication	Strength	Directio	ns	Quantity	Refills
Medication □ Vivitrol®	Strength □ 380 mg	Directio	ns	Quantity	Refills
Medication Vivitrol®	Strength □ 380 mg	□ Inject 380 mg IM	ns I q4 weeks	Quantity 1	Refills
Medication Vivitrol® 4. Prescriber and Shipping Prescriber (print):	Strength 380 mg	□ Inject 380 mg IN	nns I q4 weeks	Quantity 1	
Medication Vivitrol® 4. Prescriber and Shipping Prescriber (print):	Strength 380 mg	□ Inject 380 mg IN	nns I q4 weeks	Quantity 1	
Medication Vivitrol® 4. Prescriber and Shipping Prescriber (print): Preferred method of conta	Strength 380 mg	Office Correferred contact person	nns I q4 weeks	Quantity 1	
Medication Vivitrol® 4. Prescriber and Shipping Prescriber (print): Preferred method of conta Office Address: Phone:	Strength 380 mg Information act: phone fax email p	Office Correferred contact person	ontact:	Quantity □ 1 DEA:	
Medication Vivitrol® 4. Prescriber and Shipping Prescriber (print): Preferred method of conta Office Address: Phone: Prescriber's Signature:	Strength 380 mg Information act: phone fax email p	Office Coreferred contact person	ontact: email:	Quantity □ 1	
Medication Vivitrol® 4. Prescriber and Shipping Prescriber (print): Preferred method of conta Office Address: Phone: Prescriber's Signature:	Strength 380 mg Information act: phone fax email p fax:	Office Coreferred contact person	ontact: email: ecute the insurance	Quantity □ 1	

6. Insurance Information:

Please fax a copy of the insurance card (front and back)

*IMPORTANT NOTICE:this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and distory this document immediately. Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at www.accuservpharmacy.com for online fillable forms.