**Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

VIVITROL® REFERRAL FORM

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

FAX: 877-526-8823

Start Date

Ship To: ☐ Office ☐ Other

1. Patient Information: **Please fax front and back copy of the insurance card (Prescription and Medical)**

Patient: ______________________________ Male / Female DOB: ____________ Soc. Sec. #______________
First Name Last Name

Address: ____
Street City State Zip

Primary phone number: ______________________ Alternate phone number: ______________________

Caregiver: ______________________ Allergies: ______________________________

Comorbidities: ______________________________________ Height: ________ Weight: ________

2. Clinical information: **Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization**

ICD-10 Diagnosis: Alcohol Dependence

- ☐ **F10.229 Acute alcoholic intoxication in alcoholism unspecified drinking behavior**
- ☐ **F10.10 Acute alcoholic intoxication in alcoholism continuous drinking behavior**
- ☐ **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**
- ☐ **Other ______________________________**

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**
- ☐ **F11.2_______(fifth digit required)**
- ☐ **Other ______________________________**

3. Prescription Information: **If you need a medication not listed please contact us**

Medication	Strength	Directions	Quantity	Refills
☐ Vivitrol®	☐ 380 mg	☐ Inject 380 mg IM q4 weeks	☐ 1	

4. Prescriber and Shipping Information:

Prescriber (print):______________________________ **Office Contact:** ______________________

Preferred method of contact: ☐ **phone** ☐ **fax** ☐ **email** **preferred contact persons email:** ______________________

Office Address: ____

Phone: ________________**fax:**________________**NPI:**________________**DEA:**____________

Prescriber's Signature: ____**Date:**____________

I authorizeAccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. **(NO STAMPS)**

5. Patient Support Programs: **Please sign below to enroll in the pharmaceutical company assisted patient support program**

Patient Signature: ____**Date:**____________

6. Patient Representative:

By signing below, I authorize my Designee(s), listed below, to receive administrative information related to my treatment, such as appointment reminders, and to make decisions on my behalf – for which I will remain liable – regarding delivery of VIVITROL® (naltrexone for extended-release injectable suspension). AccuServ Pharmacy is not liable for any decision(s) made by the Designee(s) or actions taken in reliance on such Designee(s) decisions.

Please list any Designees authorized to receive administrative information related to my treatment:

Designee Name (1) ______________________ **Relationship** ____________ **Phone #** ____________

Designee Name (2) ______________________ **Relationship** ____________ **Phone #** ____________

Patient's Signature ______________________________ **Date of Signature** ____________

7. Insurance Information: **Please fax a copy of the insurance card (front & 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 destroy this document immediately.** **Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.**