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

Vivitrol Enrollment Form

Fax: (877) 526-8823

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

Start Date:_____________ **Ship to:** ___Office ___Other:___________________

1. Patient Information

Patient Name: ____ Male / Female

Address: ____

DOB:_____________Soc. Sec. # __________________ Caregiver:___________________________

Phone #:___________________ Alt Phone #:__________________Height:_______ Weight:_______

Allergies: ____

Comorbidities:____Last Neg Urine: _____________

2. Clinical Information: *Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10 Diagnosis

(If a specific code is not an option please write it in, in the space provided)

Alcohol Dependence	Opioid Dependence
____ F10.20 Alcohol dependence, uncomplicated; Alcohol use disorder ____ F10.21 Alcohol dependence, in remission; Alcohol use disorder, in remission ____ F10.229 Alcohol dependence with intoxication, unspecified ____ F10.24 Alcohol dependence with alcohol-induced mood disorder; Alcohol use disorder with alcohol-induced bipolar, depressive or related disorder ____ F10.29 Alcohol dependence with unspecified alcohol-induced disorder ____ Other: ________________________________	____ F11.20 Opioid dependence, uncomplicated; Opioid use disorder ____ F11.21 Opioid dependence in remission; Opioid use disorder in remission ____ F11.259 Opioid dependence with opioid-induced psychotic disorder, unspecified ____ Other: ______________________

3. Prescription Information *If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

✘	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
	Vivitrol®	___ 380mg	___ Inject 380 mg IM every 4 weeks ___	__ 1 PFS __	

4. Prescriber and Shipping Information

Prescriber (print) : ________________________________ Office Contact: ______________________

Pref. Method of Contact: __ phone __ fax __ email Contact email:_____________________________

Office Address:____

Phone: _________________________________ Fax: ___________________________________

NPI:___________________________________ DEA: ___________________________________

Prescriber Signature:____ Date: _______________

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

5. Insurance Information

Please fax a copy of insurance card front and back. Enlarge if possible.

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. ©2018 AccuServ Pharmacy®