Vitrivol Enrollment Form

FACTOR ONE SOURCE
FAST
PHARMACY
Powered By: InfuCare Rx

Phone: 1-833-FOS-FAST
Fax: 844-504-3278
Website: www.FOSRXFAST.com
Louisiana Office
3131 N. 1-10 Service Rd. E., Ste. 202
Metairie, LA 70002

PATIENT INFORMATION			PRESCRIBER INFORMATION	
Name:			Prescribing Practioner:	NPI:
Address:			Supervising Physician:	NPI:
City:	State/Zip:		Address:	DEA:
Telephone:	DOB: ___/___/____	M ☐ F ☐	Office:	Phone:
Language Preference:	Wt:	Ht:	Contact:	Fax:

PRIMARY INSURANCE INFORMATION

Member Name:		M ☐ F ☐	DOB: ___/___/____
Address:		City:	
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:		

PRESCRIPTION

New ☐ Refill ☐ | Ship by: ___/___/____ | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:______________________

Drug		Directions and Quantity	Refills
Vivitrol™	380mg	Inject 380mg intramuscularly every 4 weeks (Qty 1)	

DIAGNOSIS AND CLINICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

Diagnosis and ICD10: ☐ F10.20 Alcohol dependence, uncomplicated ☐ F10.21 Alcohol dependence, in remission
☐ F11.20 Opiod dependence, uncomplicate ☐ F11.21 Opiod dependence, in remission
☐ F19.20 Other psychoactive substance dependence, uncomplicated ☐ Other:_______________________

Prior meds failed: ☐ Naltrexone ☐ Other:______________________

Is patient currently receiving opioid analgesics? ☐ Yes ☐ No

Is patient currently opioid dependent? ☐ Yes ☐ No

Is patient in opioid withdrawal? ☐ Yes ☐ No

Does patient have liver disease? ☐ Yes ☐ No

Is the patient : ☐ Inpatient ☐ Outpatient

Has the patient had a negative drug screen? ☐ Yes ☐ No Date of drug screen:________________________

Documentation that the client is receiving Counseling ☐ Yes ☐ No, and/or Treatment ☐ Yes ☐ No

Current medications:

Additional Clinical Information:	**Allergies:**

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature:	Date: