# Vivitrol Enrollment Form

FACTOR ONE SOURCE FAST PHARMACY
Powered By: InfuCare Rx

**Phone:** 1-833-FOS-FAST
**Fax:** 844-533-1131
**Website:** www.FOSRXFAST.com
**Maryland Office**
217 Glenn Street Suite 300
Cumberland, MD 21502

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

| Drug | | Directions | 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 Opioid dependence, uncomplicate ☐ F11.21 Opioid 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:** |
|---|---|
| | |