

**Vivitrol  
Enrollment Form**



**FACTOR ONE SOURCE  
FAST**  
P H A R M A C Y  
Powered By: InfuCare Rx

**Phone:** 1-833-FOS-FAST  
**Fax:** 844-504-3278  
**Website:** www.FOSRXFAST.com  
**Louisiana Office**  
2400 Veterans Memorial Blvd., Suite 480  
Kenner, LA 70062

**PATIENT INFORMATION**

**PRESCRIBER INFORMATION**

Name:			Prescribing Practitioner:			NPI:		
Address:						Address:		
City:			State/Zip:			City		
Telephone:			DOB:			M <input type="checkbox"/> F <input type="checkbox"/>		
Language Preference:			Wt:			Ht:		
			Office:			DEA:		
			Contact:			Phone:		
						Fax:		

**PRIMARY INSURANCE INFORMATION**

Member Name:				M <input type="checkbox"/> F <input type="checkbox"/>		DOB: ___/___/___	
Address:				City:			
State:		Zip:		Telephone:		Alt. Telephone:	
Member ID:			Rx Group #:			BIN#:	
PCN#:			Customer Service #:				

**PRESCRIPTION**

New <input type="checkbox"/> Refill <input type="checkbox"/>		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, uncompliate  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:

<b>Additional Clinical Information:</b>	<b>Allergies:</b>
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**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.

<b>Prescribing Practitioner Signature:</b>	<b>Date:</b>
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