WELLPARTNER PHARMACY | VIVITROL ENROLLMENT FORM

wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

- ◯ F10.20 Alcohol dependence, uncomplicated
- ◯ F10.21 Alcohol dependence, in remission
- ◯ F11.20 Opioid dependence, uncomplicated
- ◯ F11.21 Opioid dependence, in remission
- ◯ F19.20 Other psychoactive substance dependence, uncomplicated
- ◯ Other:

Height (in/cm): Weight (lb/kg):

Allergies:

Concomitant Medications:

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

Specialty pharmacy to coordinate injection administration/home health nurse visit as necessary.

◯ Yes ◯ No

◯ Injection administration/home health nurse visit coordination not necessary.

Reason: ◯ MD office to administer to patient

◯ Injection administration/home health nursing already coordinated

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Vivitrol™	◯ 380 mg vial kit (for intramuscular injection)	◯ Administer 380 mg intramuscularly every 4 weeks (28 days). ◯ Administer 380 mg intramuscularly once a month (30 days).	◯ One 380 mg vial kit (includes supplies) ◯	
◯				
◯				
◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE