

Patient Name _____ Today's Date _____ NEW Patient CURRENT Patient
 DOB _____ Height _____ Weight _____ Male Female Preferred Language _____
 Best Phone _____ Email _____
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Ship to Patient at: Home Physician Office Work Address _____
 Allergies _____
 Current Medications including OTC's (please fax a complete list) _____

Please Fax Insurance Card(s) both sides

Insured's Name _____
 Relation to Patient _____
Primary Insurance _____
 ID# _____ Group # _____
Secondary Insurance _____
 ID# _____ Group # _____

Ordering Prescriber

Office Contact _____
 Street Address _____ Suite # _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____
 Email _____
 License# _____
 NPI# _____

Patient has tried and failed the following therapy or medication(s): _____

- Yes No If the diagnosis is alcohol or drug dependence, will the patient abstain from using any alcohol or drugs?
 Yes No Will treatment be part of a comprehensive management program that includes psychosocial support?

ALCOHOL DEPENDENCE ICD-10 Codes

- F10.29** Alcohol dependence with intoxication, unspecified **F10.20** Alcohol dependence, uncomplicated
 F10.21 Alcohol dependence, in remission **F10.23** Alcohol dependence with withdrawal
 Other ICD-10 Code: _____

For patients with ALCOHOL DEPENDENCE complete the following:

- Yes No Does the patient acute hepatitis/liver failure?
 Yes No Is the patient actively consuming alcoholic beverages at this time?
 Yes No Has the patient abstained from alcohol in the outpatient setting prior to the initiation of Vivitrol?

OPIOID DEPENDENCE ICD-10 Codes

- F11.20** Opioid dependence, uncomplicated **F11.9** Opioid use, unspecified
 F11.21 Opioid dependence, in remission **F19.20** Other psychoactive substance dependence, uncomplicated
 F11.23 Opioid dependence with withdrawal **F19.21** Other psychoactive substance dependence, in remission
 Other ICD-10 Code: _____

For patients with OPIOID DEPENDENCE complete the following:

- Yes No Is the patient receiving any opioid analgesics?
 Yes No Is the patient in acute opiate withdrawal?
 Yes No Is the patient opioid-free for at least 7-10 days based on testing prior to initiation of Vivitrol?

PRESCRIPTION

VIVITROL
(naltrexone) 380mg single use kit (for intramuscular injection)

SIG: Inject 380mg IM 28 days
 Inject 380mg IM every _____ days
 Inject 380mg IM once every month
 Other _____

Dispense: 28-day supply 84-day supply
 Other _____ Refills _____

I, The patient signing below, giving my consent to my Fulfilling Pharmacy, Giannotto's Specialty Pharmacy that an agent of the pharmacy can perform Eligibility, benefit verification, send claims to my insurance in my behalf, inquire and assist in receiving Copay assistance and to communicate with my Healthcare Provider to coordinate the delivery of my prescribed medication for my next scheduled dose either at Office or at home. I understand that this serves as a patient authorization to BILL & ship, which means the Fulfilling Pharmacy may not contact me and/or my Designated Contact, prior to shipping medication as long as they have communicated with my Prescriber or their agents.

Patient Signature _____

Will your office be injecting Vivitrol?

- Yes, all doses at our practice:**
 No, Please visit provider indicated:

Practice _____
 Address _____
 City, Street, ZIP _____
 Phone: _____ Fax: _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes Giannotto's Specialty Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: Giannotto's Specialty Pharmacy can only accept original prescription drug orders from patients. Faxed prescriptions can be accepted only from the prescribing practitioners.