



A Carelon Company

# VIVITROL (NALTREXONE) INJECTION ORDERS

**P:** 877-365-5566 | **F:** 855-889-2946

**PATIENT INFORMATION** Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Allergies:				
<b>Diagnosis Code ICD-10 (required):</b>			<b>Diagnosis Description:</b>	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy			Next Treatment Date:	

**PHYSICIAN INFORMATION**

Prescriber Name:		Phone:	Fax:
Office Contact:		Email:	
Address:		City:	State: ZIP:
NPI #:	DEA#:	Tax ID:	

**INSURANCE INFORMATION (or attach copy of cards)**

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

**PRESCRIPTION INFORMATION (or attach a copy of the prescription)**

Drug	Dosing	Refills
<b>Vivitrol</b> (naltrexone)	<input type="checkbox"/> 380mg IM once monthly <input type="checkbox"/> Other: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Other orders: \_\_\_\_\_

Lab Orders: \_\_\_\_\_ Frequency: \_\_\_\_\_

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.  Dispense as written

**PRESCRIBER SIGNATURE** By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

**Prescriber Signature: X** **Date:** \_\_\_\_\_



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## COMPREHENSIVE SUPPORT FOR VIVITROL (NALTREXONE) THERAPY

### PATIENT INFORMATION

Name:

DOB:

### REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) to support primary diagnosis
- Labs attached (if applicable)
- Has the patient been opioid/alcohol free for at least 7 days prior to treatment?
  - Yes  No Date of last use: \_\_\_\_\_
- Other medical necessity: \_\_\_\_\_