**Note:** This prescription is valid only if transmitted by facsimile from the prescriber's office. This form is not a valid prescription in Arizona or Virginia. Physician must attest that this is his/her legal signature (no stamps). Prescriber must comply with his/her state-specific requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form below should only be used if permitted by the applicable laws in your state.

# Vivitrol® Prescription & Enrollment Form

(naltrexone for extended-release injectable suspension)

genoa healthcare

## Patient Information

Patient Name: _____ Date of Birth: _____

Sex: ☐Male ☐Female ☐Other Height: _____ Weight: _____ ☐lb ☐kg

Address: _____ City, State, ZIP: _____

Home Phone: _____ Cell: _____ Email: _____

Primary Language: _____ Known Allergies: _____

Emergency Contact and Phone: _____

☐ Patient is new to Vivitrol therapy

## Insurance Information

Primary Insurance: _____ Policy / Member ID: _____
Group #: _____

Secondary Insurance (if applicable): _____ Policy / Member ID: _____
Group #: _____

## Prescriber Information

Prescriber Name: _____

Credentials: _____ Practice/Facility Name: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax: _____

Email: _____ NPI #_____

Prescriber Signature: _____ Date: _____

## Medication Order

Medication: Vivitrol® (naltrexone for extended-release injectable suspension)

Dose: 380 mg intramuscular injection Frequency: ☐ Every 4 weeks (monthly)

Quantity: ☐ 1 dose Number of Refills: _____

Anticipated Date of Administration: _____

## Diagnosis (ICD-10)

☐ F10.20 – Alcohol dependence, uncomplicated ☐ F10.21 – Alcohol dependence, in remission

☐ F11.20 – Opioid dependence, uncomplicated ☐ F11.21 – Opioid dependence, in remission

☐ Other: _____

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