☐ *Borough Park*
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Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57 West 57 Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

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☐ *Queens*
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Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Mission Medical

# ORDER FORM VIVITROL®

Date: _____

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name: | DOB: | SEX: M ☐ F ☐ |
| Allergies: | Date of Referral: | |

## PHYSICIAN INFORMATION

| | |
|---|---|
| Physician Name*: | Practice Name: |
| Address: | Office Contact*: |
| Phone: Fax: | Email (for updates): |

## REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

## Prescriber Information

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office clinic/institution name _____ Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Deliver product to: Office Clinic

## Clinical Information

Primary ICD-10 code: _____ Has the patient been on therapy before? Yes Date of last dose _____ No

Please provide clinical documentation of response: _____

If the diagnosis is alcohol or drug dependence, will the patient abstain from using alcohol or drugs? Yes No

Will treatment be part of a comprehensive management program that includes psychosocial support? Yes No

Does the patient have the following? Yes No • Receiving opioid analgesics • With current physiologic opioid dependence

• Is in acute opiate withdrawal • Failed the naloxone challenge test or has a positive urine screen for opioids
• Who has acute hepatitis/liver failure

| Medication | Strength/Formulation | Directions | Quantity/Refills |
|---|---|---|---|
| ☐ Vivitrol®(naltrexone) | 380mg single use carton | ☐ Inject 380mg IM every 28 days<br>☐ Inject 380mg IM every _____ days | Dispense:<br>☐ 28-day supply<br>☐ 84-day supply<br>☐ Other<br>_____<br>Refills _____ |
| Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. as needed to administer the therapy | | | Send quantity sufficient for medication days supply |

**ORDERING PROVIDER**

Signature X _____ Date _____ Provider _____

Phone _____ Fax _____