VIVITROL
PATIENT ENROLLMENT

Phone: (888) 370.1724 Fax: (402) 896.3774
10004 S. 152nd St, Suite A, Omaha NE 68138

Complete all fields to avoid processing delays. Fax Completed Form to: 877-645-7514.
Questions? Call 888-370-1724, 7am–7pm (CST).

Prescriber or Facility Information

Prescriber Name*	Prescriber Phone #	NPI #	Facility Name

Fax #	Address	City	State	ZIP Code

Staff Contact Name	Staff Contact E-mail	Staff Contact Phone #

Patient Information

Name (First)	(Last)	Date of Birth	Gender ❑ Female ❑ Male

Address	City	State	ZIP Code	Home Phone #

Mobile Phone #	Best Number to Call ❑ Home ❑ Mobile	Best Day to Call ❑ M ❑ T ❑ W ❑ TH ❑ F

Best Time to Call ❑ Morning ❑ Afternoon ❑ Evening	E-mail Address

Patient Diagnosis

❑ Alcohol Dependence ❑ Opioid Dependence	ICD-10	
❑ New Therapy ❑ Existing Therapy	If existing therapy, provide date of last dose:	

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

Patient's concurrent medications (if applicable):	Please list any known allergies to medications or other substances:

Patient Insurance Information

A. ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD(S). B. IF YOU ELECT NOT TO ATTACH AN INSURANCE CARD, COMPLETE SECTION BELOW.	Insurance Plan

Policy/ID #	Group #	BIN #	PCN

Injection Information

Will your patient receive ongoing injections at your location?

- ❑ Yes, patient will recieve all injections at this location.
- ❑ No, patient is in treatment facility and will transition to new provider. Admittance Date:___/___/_____ Estimated Discharge date:___/___/_____
  - ❑ A new provider is unknown; need assistance from Amber Pharmacy to locate one.
  - ❑ Amber Pharmacy should contact provider below to coordinate ongoing care for this patient

Provider Name	Phone #	Provider Address

Shipping

Patient needs VIVITROL delivered by date _____/_____/_____

Special shipping instructions or other information:

Prescription Information *Prescriber Signature must be the same as the Prescriber name above

VIVITROL 380 mg x 1 unit Inject 380 mg IM every 4 weeks or every 1 month

Refill: _______ times (Complete refills to minimize interruption in monthly VIVITROL therapy)

Prescriber's Signature X ________________________________ (If applicable Prescriber's Signature (no stamps allowed)

X ______________________ X ______________________ **Date of Signature** ______________

Dispense as written **Substitution Permitted**

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