

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

EMAIL: specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION	
Name:	
Address:	
City, State, ZIP:	
Primary Phone: - -	DOB: / /
Alternate Phone: - -	Gender:
Email:	
Primary Language:	Last Four of SSN:

2. PRESCRIBER INFORMATION		
Name:		
DEA #:	NPI #:	State Lic. #:
Group or Hospital:		
Address:		
City, State, Zip:		
Phone: - -	Fax: - -	
Contact Person:	Phone: - -	

3. INSURANCE INFORMATION		<i>Fax copy of prescription and insurance cards with this form, if available (front and back)</i>	
Primary Insurance Company Name:		Secondary Insurance Company Name:	
Primary Cardholder Name:		Secondary Cardholder Name:	
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent		Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	
Phone: - -	Member ID:	Group #:	

4. DIAGNOSIS AND CLINICAL INFORMATION	
Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /	Is patient currently receiving opioid analgesics? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> F10.20 Alcohol dependence, uncomplicated	Is patient currently opioid dependent? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> F10.21 Alcohol dependence, in remission	Is patient in opioid withdrawal? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> F11.20 Opioid dependence, uncomplicated	Does patient have liver disease? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> F11.21 Opioid dependence, in remission	Specialty pharmacy to coordinate injection administration/home health nurse visit as necessary.
<input type="radio"/> F19.20 Other psychoactive substance dependence, uncomplicated	<input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Other:	<input type="radio"/> Injection administration/home health nurse visit coordination not necessary.
Height (in/cm):	Weight (lb/kg):
Allergies:	Reason: <input type="radio"/> MD office to administer to patient
Concomitant Medications:	<input type="radio"/> Injection administration/home health nursing already coordinated

5. PRESCRIPTION INFORMATION				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Vivitrol™	<input type="radio"/> 380 mg vial kit (for intramuscular injection)	<input type="radio"/> Administer 380 mg intramuscularly every 4 weeks (28 days). <input type="radio"/> Administer 380 mg intramuscularly once a month (30 days).	<input type="radio"/> One 380 mg vial kit (includes supplies) <input type="radio"/>	
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE	
X _____ / /	X _____ / /
DISPENSE AS WRITTEN	DATE
PRODUCT SUBSTITUTION PERMITTED	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.