Vivitrol

Provider Order Form

PATIENT INFORMATION

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Address:	City:	State:	Zip Code:
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
☐ NKDA ☐ Allergies:		Weight lbs/kg:	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change		Last infusion date (if applicable):	

REQUIRED DOCUMENTATION

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

Alcohol Dependence

☐ 303.90 - Other and unspecified alcohol dependence unspecified drinking behavior
☐ 303.91 - Other and unspecified alcohol dependence continuous drinking behavior
☐ 303.92 - Other and unspecified alcohol dependence episodic drinking behavior
☐ 303.93 - Other and unspecified alcohol dependence dependence in remission

Other: _____

Opioid Dependence

304.00 - Opioid type dependence unspecified use
304.01 - Opioid type dependence continuous use
304.02 - Opioid type dependence episodic use
304.03 - Opioid type dependence in remission
304.7 Combination of opioid type drug w ith any other drug dependence (fifth digit required)

Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO
Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
Cetirizine (Zyrtec) ☐ 10mg PO
Methylprednisolone (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV
Loratadine (Claritin) ☐ 10mg PO
Hydrocortisone (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Vivitrol

Dose: ☐ 380mg vial Kit (for intramuscular injection)
Directions ☐ Administer 380mg intramuscularly every 4 w eeks (28 days)
Frequency: ☐ One 380mg vial Kit (includes supplies)* - see below

**Vivitrol® Kit Includes: Vial of Vivitrol microspheres, Vial of diluent, One 20G 1/2" preparation needle, Tw o 20G 1 & 1/2" administration needles*

PROVIDER INFORMATION

Provider Name:	Provider Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.