

# Vivitrol Enrollment Form

Fax Referral To: 1-855-460-0682 | Phone: 1-800-368-0903 | Email Referral To: [Customer.ServiceFax@CVSHealth.com](mailto:Customer.ServiceFax@CVSHealth.com)

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION (Patient must complete highlighted area) Scheduled Injection Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City, State, ZIP Code: \_\_\_\_\_ DOB: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Gender:  Male  Female  
 Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty about your prescription(s), account and healthcare. Standard data rates apply. Message frequency varies.*

#### Designated Patient Contact

By signing below, I authorize my Contact, listed below, to receive logistical and administrative information related to my treatment, including ability to make decisions on my behalf, for which I will remain liable, regarding delivery of Vivitrol (naltrexone extended-release injectable suspension). CVS Specialty is not liable for any decision(s) made by the Contact or actions taken in reliance on such Contact decisions. Please list any authorized Contact as set forth above:

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**➔ Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### Patient Authorization

I hereby authorize CVS Specialty to contact my prescribing provider, on my behalf, to coordinate the delivery, receipt and storage of my Vivitrol prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. I understand that my signature below serves as the Patient Ship Authorization, which means the pharmacy will not outreach/contact me and/or my designated contact on this form, prior to shipping medication except in certain circumstances.\*\* I further agree to pay to CVS Specialty any required copayment or coinsurance amount, up to a total amount of \$50, without prior outreach to me or my designated contact.

**➔ Patient's Authorization:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*CVS Specialty may contact patient and/or patient's designee in the event the patient's copay/coinsurance responsibility is greater than \$50. Enrollment above is not available to Medicare and Medicaid patients because government payors are excluded from this offering. Copayment, copay or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

### 2 PRESCRIBER INFORMATION

Facility Type:  Private Practice  Outpatient Hospital/Clinic  Inpatient Facility  Correctional  
 Prescriber's First Name: \_\_\_\_\_ Prescriber's Last Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ State License#: \_\_\_\_\_ DEA#: \_\_\_\_\_  
 Practice/Facility Name: \_\_\_\_\_ Practice NPI#: \_\_\_\_\_  
 Practice Address (Ship to Address): \_\_\_\_\_ City: \_\_\_\_\_ State/ZIP Code: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

### 3 INSURANCE INFORMATION (Please fax copy of prescription/medical insurance cards with this form, front and back)

Is the Patient Insured?  Yes  No Is the Patient enrolled or eligible for Medicare/Medicaid?  Yes  No  
 Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Medical Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Prescription Insurance: \_\_\_\_\_ Prescription Plan Telephone: \_\_\_\_\_  
 Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_ RX BIN #: \_\_\_\_\_ RX PCN #: \_\_\_\_\_  
 Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID#: \_\_\_\_\_

### 4 DIAGNOSIS AND CLINICAL INFORMATION (to be completed by prescriber only)

Allergies: \_\_\_\_\_ Has patient previously been treated for Alcohol Use Disorder?  Yes  No  
 Has patient previously been treated for Opioid Use Disorder?  Yes  No  
 If YES, list all previous medications: \_\_\_\_\_  
 List concomitant medications (e.g., adjunctive depression medications, sedative hypnotics, psychostimulants): \_\_\_\_\_

Alcohol Dependence		Opioid Dependence	
<input type="checkbox"/> F10.20 Alcohol dependence, uncomplicated		<input type="checkbox"/> F11.20 Opioid dependence, uncomplicated	
<input type="checkbox"/> F10.21 Alcohol dependence, in remission		<input type="checkbox"/> F11.21 Opioid dependence, in remission	
<input type="checkbox"/> F10.23 Alcohol dependence with withdrawal		<input type="checkbox"/> F11.23 Opioid dependence with withdrawal	
<input type="checkbox"/> F10.9 Alcohol use, unspecified		<input type="checkbox"/> F11.9 Opioid use, unspecified	
<input type="checkbox"/> Other Code: _____ Description: _____		<input type="checkbox"/> Other Code: _____ Description: _____	

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Vivitrol	380 mg vial Kit (for intramuscular injection) Kit includes: Vial of Vivitrol microspheres, Vial of diluent, One 20 G 1/2" preparation needle, Two 20 G 1 1/2" administer needles	<input type="checkbox"/> Administer 380 mg intramuscularly every 4 weeks (28 days) <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> One 380 mg vial kit <input type="checkbox"/> Other: _____ Refills: _____

**NOTE:** Prescriber must comply with his/her state-specific prescription 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 law in your state.

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

May Substitute/ Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	Dispense As Written/ Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
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**CA, MA, NC & PR:** Interchange is mandated unless Prescriber writes the words "No Substitution"  
**ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature. I have obtained written authorization from the Patient to disclose the Patient's personal health information and any other information on this enrollment form as may be required to comply with all applicable federal and state laws and regulations, including, but not limited to, the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164) and the Confidentiality of Substance Use Disorder Patient Records Regulation (42 C.F.R. Part 2), as amended from time to time. CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates. ©2022 CVS Specialty and/or one of its affiliates. 75-44204A 11/07/22