MATRxVIP

MATRIX VIP PHARMACY
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Questions? E-mail us at **INFO@MATRIX-PHARMACY.COM** or Call **(412) 586-4545**. We are here to assist you!

VIVITROL® ENROLLMENT FORM

PATIENT INFORMATION & DEMOGRAPHICS

ORDER DATE: ____________________ **APPOINTMENT DATE (if known):** __________________

LAST NAME: ____________________________ **FIRST NAME:** ____

ADDRESS: ____

CITY:________________________________ **STATE:** ____________ **ZIP:** ______________________

PHONE: ______________________________________ **DOB:** ___________________ ☐ **Female** ☐ **Male**

INSURANCE COMPANY: _____________________________________ **ID#:**_______________________

GROUP#: ____________________ **EMERGENCY CONTACT:** ____

PRESCRIPTION INFORMATION

DIAGNOSIS: ☐ **F11.2__** **(Opioid dependence)** ☐ **F10.2___** **(Alcohol dependence)**

ALLERGIES: ☐ **NKA**

☐ **VIVITROL®** (naltrexone for extended-release injectable suspension) **380mg Kit**
Directions: Inject 380mg Intramuscularly Every 4 Weeks **Quantity:** 1 (One) Kit **Refills:** _________

Drug Name: ____**Strength:**___________________________
Directions:____ **Quantity:**_____________**Refills:**________

PRESCRIBER INFORMATION

OFFICE/CLINIC NAME: ________________________________ **ATTN:** ______________________________

OFFICE ADDRESS: ____

CITY:____ **STATE:** _________ **ZIP:** ________________

PHONE: ______________________________ **FAX:**__________________________

PRESCRIBER NAME ____

NPI: ______________________________ **LICENSE:** ________________ **DEA:** ______________________

PRESCRIBER SIGNATURE:____ **DATE:** ______________

(substitution permissible if applicable)

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE ''BRAND NECESSARY'' OR ''BRAND MEDICALLY NECESSARY'' IN THE SPACE BELOW.

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