



Addiction Recovery Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ Group#: _____

Diagnosis

F11.20 Opioid Dependence F10.20 Alcohol Dependence Other _____

Clinical Information

Please attach clinical notes, lab results, and supportive documentation of behavioral health enrollment to expedite the prior authorization.

Is the patient currently in a comprehensive treatment plan that includes psychosocial support? Yes No
 Has patient tried and tolerated oral Naltrexone? Yes No
 Has the patient been opioid free for a minimum of 7-10 days prior to therapy treatment? Yes No
 Does the patient have documentation of recent urine drug screen and/or blood alcohol screen? Yes Date: _____ No
 Has the patient been screened for hepatitis/liver failure? Yes No
 Start of Care Date: _____/_____/_____
 Anticipated Injection Date: _____/_____/_____

Prescription

Medication	Directions	Quantity	Refills
Vivitrol Kit 380mg (includes medication, diluent, administration supplies)	Prescriber to inject contents of one vial intramuscularly every 28 days	#1	

After Care Plan

Anticipated date of discharge? _____/_____/_____ Place of discharge unknown Yes No
 Place of discharge: _____ Location: _____ Phone Number: _____

Is patient new to this therapy? YES NO | Ship to: Patient Office Other

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____ Preferred Method: Phone Fax Email
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Email: _____

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

fax referral to: **901-388-0407** | phone: **877-388-0507** | **www.restorerx.com**