Addiction Recovery Enrollment Form

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**