VIVITROL (naltrexone) Referral Order Form

FAX (877) 637-6691

WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)* _____

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

VIVITROL MEDICATION ORDERS

☐ Dosing: 380mg

Inject 380mg IM once every 4 weeks or once a month

INDICATION/DIAGNOSIS

☐ Alcohol dependence, maintenance of abstinence
☐ Opioid dependence, relapse following detoxification; prophylaxis

***ICD-10 _____ required**

_____ _____
Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes)
☐ Lab Results
☐ Insurance Cards (front and back)
☐ Current Medication List
☐ Demographic Sheet
☐ History and Physical Report

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY