



PLEASE COMPLETE ALL FIELDS TO AVOID PROCESSING DELAYS

PRESCRIBER INFORMATION	PATIENT INFORMATION
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Prescriber Name:		Patient Name:	
State License #	DEA #	DOB:	SSN: Gender: M F
Prescriber Phone #		Patient Address:	
Facility Name:	NPI #	City, State:	Zip:
Address:		Patient Preferred Phone Contact #	
City, State:	Zip:	Patient Email Address:	

Staff Contact Name: _____
 Staff Contact Phone # _____
 Staff Contact Email: _____

Patient Diagnosis—Please complete the diagnosis code(s) by filling in the additional digits.

Alcohol Dependence	Opioid Dependence
ICD-10	ICD-10
F10. _____	F11. _____
F10. _____	F11. _____
F10. _____	F11. _____
F10. _____	F11. _____
F10. _____	F11. _____

INJECTION PROVIDER INFORMATION

Will your office/facility be injecting VIVITROL?
 Yes, ALL doses
 No, the doses will shipped to and administered by the following:

Provider Name: _____
 Phone # _____
 Provider Address: _____
 City, State: _____ Zip: _____

PATIENT HAS TRIED & FAILED THE FOLLOWING MEDICATION(S):

PATIENT INSURANCE INFORMATION

Pharmacy Benefit Plan (PBM)—Required for Co-Pay card activation

ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD(S)

Payment Method: Insured Paying Out-of-Pocket

PBM Name and Phone # _____
 Policyholder Name _____ Relationship to Patient _____
 Policy # _____ Rx Grp: _____
 RxPCN: _____ Rx BIN# _____

PRESCRIPTION INFORMATION

- VIVITROL 380 mg x 1 unit inject 380 mg IM every 4 weeks or every 1 month

Refill _____ times (Complete refills to minimize interruption in 1 monthly VIVITROL therapy)

PROVIDER ATTESTATION
**Prescriber signature must be the same as the prescriber name above*

Prescriber's Signature: _____ Date: _____
 By signing this form and utilizing our services, you are authorizing Duncan Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.