Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Lifeline Specialty Pharmacy

Vivitrol Referral Form

3233 Corporate Ct.
Ellicott City, MD 21043

LIFELINE SPECIALTY PHARMACY

Send your Rx to: **Fax Number: 410-203-1515**
Phone Number: 410-203-1010

Toll Free Number: 1-833-4-LIFELINE

NPI: 1568975464

If you have questions or concerns, please contact us.

Date Medication Needed:_____ **Ship To:** ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-up (store location):_____ Injection training by pharmacy? ☐

1: Patient Information

Patient Name:_____ **Birthdate:**_____ **Sex:** ☐ Male ☐ Female **Height:**____ :_____ ☐ lbs. ☐ g.

Soc. Sec. #:_____ **Preferred Phone:**_____ **Known Allergies:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Alternate Caregiver Name:_____ **Preferred Phone:**_____

2: Insurance Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Primary Prescription Insurance_____ **Rx Bin**_____

Rx PCN_____ **Patient ID/Policy Number**_____ **Patient Rx Group Number**_____

3: Prescriber Information

Provider Name:_____ **DEA#:**_____ **NPI#:**_____ **Tax ID#:**_____

Address:_____ **Phone:**_____ **Fax:**_____

City, State, Zip:_____ **Key Contact:**_____ **Phone:**_____

4: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis and ICD-10:

☐ F10.20 Alcohol dependence, uncomplicated ☐ F10.21 Alcohol dependence, in remission

☐ F11.20 Opiod dependence, uncomplicated ☐ F11.21 Opiod dependence, in remission

☐ F19.20 Other psychoactive substance dependence, uncomplicated ☐ Other_____

Prior Failed Medications:

☐ Naltrexone ☐ Other_____

Is patient currently receiving opioid analgesics? ☐ Yes ☐ No **Is patient currently opioid dependent?** ☐ Yes ☐ No

Is patient in opioid withdrawal? ☐ Yes ☐ **Does patient have liver disease?** ☐ Yes ☐ No

The patient is: ☐ Inpatient ☐ Outpatient **Has the patient had a negative drug screen?** ☐ Yes ☐ No **Date of drug screen**_____

Documentation that the patient is receiving counseling: ☐ Yes ☐ No and/or Treatment ☐ Yes ☐ No

Current Medications_____

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Vivitrol**	☐ 380mg	☐ Inject 380mg intramuscularly every 4 weeks		

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Substitution Permissable Date Dispense as written Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

# of Prescriptions: _____