Directions to Enroll Patient:

1. Complete Enrollment Form
2. Attach Prescription & Insurance Card
3. **Fax to Americare Specialty Pharmacy**

Fax# (516)292-5103 Phone# (516)292-7788
Email: Specialty@AmericarePS.com

VIVITROL PHARMACY REFERRAL

Americare PS™ PHARMACEUTICAL SERVICES

317 Nassau Blvd,
Garden City, NY 11530

Today's Date:	**Needs by Date:**

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other** **We will ship 1st dose upon approval and ship monthly refills based on provider request and consent**

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Email Address: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female

Prescriber Information

Prescriber's Name: _____
State License #: _____ DEA #: _____
NPI #: _____
Facility Name: _____
Address: _____
City, State, Zip: _____
Phone #: _____ Fax #: _____
Staff Contact Name: _____ Email: _____

Insurance Information (Please attach a copy of both sides of the Patient's Insurance Card)

Carrier Name: _____ Carrier Phone #: _____ ID #: _____
Policyholder Name: _____ Policyholder Employer Name: _____ Grp #: _____
Relationship to Pt: _____ Bin #: _____

Statement of Medical Necessity

Patient Diagnosis:

Alcohol Dependence		Opioid Dependence	
ICD-9	ICD-10	ICD-9	ICD-10
303._____	F10._____	304._____	F11._____
303._____	F10._____	304._____	F11._____
303._____	F10._____	304._____	F11._____
303._____	F10._____	304._____	F11._____
303._____	F10._____	304._____	F11._____
Other: _____		Other: _____	
Date: _____		Date: _____	

Clinical Information:

Is the patient currently receiving opioid analgesics? ☐ Yes ☐ No
Is the patient currently opioid dependent? ☐ Yes ☐ No
Is the patient in opioid withdrawal? ☐ Yes ☐ No
Does the patient have liver disease? ☐ Yes ☐ No
Concomitant Medications: _____
Allergies: _____

☐ Patient has had prior detoxification and/or residential treatment for alcohol/opioid dependence, indicating a lack of success of traditional treatment approach and need for a long-lasting medication.
☐ Patient has a history of non-compliance with other treatments and/or medications.
☐ Patient does not have a family or social support system that will assist in their daily taking of oral naltrexone.
☐ Patient has a co-occurring mental health condition that impacts their decision making capabilities to be compliant with treatment recommendations.

Prescription Information

Medication	Strength	Directions	Quantity	Refills
☐ Vivitrol®	☐ 380mg vial Kit (for intramuscular injection)	☐ Administer 380mg IM *every* 4 weeks (*28 days*) ☐ Administer 380mg IM *once* a month (*30 days*)	☐ One 380mg vial Kit (Includes supplies) ☐ Other: _____	_____

MUST SEND ELECTRONIC RX, FAX OFFICIAL NYS PRESCRIPTION FORM (WITH BARCODE), OR CALL IN RX TO US

I have chosen Americare Pharmaceutical Services Inc. NPI 1679678049, and its employees as an Authorized Agent to assist my staff in handling many of the responsibilities associated with fulfilling the medication requirements of my patients, including specialty medications. These responsibilities include but are not limited to, requesting Prior Authorizations for my patients, answering the criteria questions for the coverage determination within the Prior Authorization Request forms, receiving the Prior Authorization determination from PBMs, as well as any other duties or requirements needed to properly perform a Prior Authorization for my patients. As my Authorized Agent, Americare Pharmaceutical Services, Inc. has been provided all of the required information to accurately complete Prior Authorizations.

Provider Attestation

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

Prescriber's Signature _____ **Date of Signature** _____