Vivitrol Enrollment and Patient Consent Form

e-Prescribe: NCPDP-3958898 | Fax Referral To: 1-855-460-0682 | Phone: 1-800-368-0903 | Email Referral To: Customer.ServiceFax@CVSHealth.com

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Patient must complete highlighted area)

Scheduled Injection Date: _____

Patient Name: _____ Address: _____

City, State, ZIP Code: _____ DOB: _____ Last Four of SSN: _____ Gender: ☐ Male ☐ Female

Primary Phone: _____ Alternate Phone: _____ Email: _____

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

Note: Carrier Charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Designated Patient Contact

By signing below, I authorize my Contact, listed below, to receive logistical and administrative information related to my treatment, including ability to make decisions on my behalf, for which I will remain liable, regarding delivery of Vivitrol (naltrexone extended-release injectable suspension). CVS Specialty is not liable for any decision(s) made by the Contact or actions taken in reliance on such Contact decisions. Please list any authorized Contact as set forth above:

Contact Name: _____ Relationship: _____ Phone: _____

Patient's Signature: _____ Date: _____

Patient Authorization

I hereby authorize CVS Specialty to contact my prescribing provider, on my behalf, to coordinate the delivery, receipt, and storage of my Vivitrol prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. I understand that my signature below serves as the Patient Ship Authorization, which means the pharmacy will not outreach/contact me and/or my designated contact on this form, prior to shipping medication except in certain circumstances.** I further agree to pay to CVS Specialty any required copayment or coinsurance amount, up to a total amount of $50, without prior outreach to me or my designated contact.

Patient's Authorization: _____ Date: _____

***CVS Specialty may contact patient and/or patient's designee in the event the patient's copay/coinsurance responsibility is greater than $50. Enrollment above is not available to Medicare and Medicaid patients because government payors are excluded from this offering. Copayment, copay, or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.*

2 PRESCRIBER INFORMATION

Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Facility ☐ Correctional

Prescriber's First Name: _____ Prescriber's Last Name: _____ NPI#: _____ State License#: _____ DEA#: _____

Practice/Facility Name: _____ Practice NPI#: _____

Practice Address (Ship to Address): _____ City: _____ State/ZIP Code: _____

Phone Number: _____ Fax Number: _____ Office Contact Name: _____ Contact's Phone: _____

3 INSURANCE INFORMATION (Please fax copy of prescription/medical insurance cards with this form, front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No

Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Telephone: _____

Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID#: _____

4 DIAGNOSIS AND CLINICAL INFORMATION (to be completed by prescriber only)

Allergies: _____ Has patient previously been treated for Alcohol Use Disorder? ☐ Yes ☐ No

Has patient previously been treated for Opioid Use Disorder? ☐ Yes ☐ No

If YES, list all previous medications: _____

List concomitant medications (e.g., adjunctive depression medications, sedative hypnotics, psychostimulants): _____

_____

Alcohol Dependence	Opioid Dependence
☐ F10.20 Alcohol dependence, uncomplicated	☐ F11.20 Opioid dependence, uncomplicated
☐ F10.21 Alcohol dependence, in remission	☐ F11.21 Opioid dependence, in remission
☐ F10.23 Alcohol dependence with withdrawal	☐ F11.23 Opioid dependence with withdrawal
☐ F10.9 Alcohol use, unspecified	☐ F11.9 Opioid use, unspecified
☐ Other Code: _____ Description: _____	☐ Other Code: _____ Description: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Vivitrol	380 mg vial Kit *(for intramuscular injection)* Kit includes: Vial of Vivitrol microspheres, Vial of diluent, One 20 G ½" preparation needle, Two 20 G 1&½" administer needles	☐ Administer 380 mg intramuscularly *every 4 weeks (28 days)* ☐ Other: _____	Quantity: ☐ One 380 mg vial kit ☐ Other: _____ Refills: _____

***NOTE**: Prescriber must comply with his/her state-specific prescription requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution, or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form below should only be used if permitted by the applicable law in your state.*

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

May Substitute/ Product Selection Permitted / Substitution Permissible	Dispense As Written/ Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: _____ **Date:** _____	**Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____

ATTN: New York and Iowa providers, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature. I have obtained written authorization from the Patient to disclose the Patient's personal health information and any other information on this enrollment form as may be required to comply with all applicable federal and state laws and regulations, including, but not limited to, the HIPAA Privacy Rule (45C.F.R. Parts 160 and 164) and the Confidentiality of Substance Use Disorder Patient Records Regulation (42 C.F.R. Part 2), as amended from time to time. CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.