MATRIXVIP

MATRIX VIP PHARMACY
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Phone (866) 410-3306 Fax (866) 410-3304

Questions? E-mail us at **INFO@MATRIX-PHARMACY.COM** or Call **(866) 410-3306**. We are here to assist you!

VIVITROL® ENROLLMENT FORM

PATIENT INFORMATION & DEMOGRAPHICS

ORDER DATE: _____ **APPOINTMENT DATE (if known):** _____

LAST NAME: _____ **FIRST NAME:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **DOB:** _____ ☐ **Female** ☐ **Male**

INSURANCE COMPANY: _____ **ID#:** _____

GROUP#: _____ **EMERGENCY CONTACT:** _____

PRESCRIPTION INFORMATION

DIAGNOSIS: ☐ **F11.2**____ **(Opioid dependence)** ☐ **F10.2**____ **(Alcohol dependence)**

ALLERGIES: ☐ **NKA** ☐ _____

☐ **VIVITROL®** (naltrexone for extended-release injectable suspension) **380mg Kit**
Directions: Inject 380mg Intramuscularly Every 4 Weeks **Quantity:** 1 (One) Kit **Refills:** _____

☐ **NARCAN** (naloxone HCL) Use 2 sprays Intranasally in an opioid overdose emergency **Qty:** 2 **Refills:** None

☐ **Drug Name:** _____ **Strength:** _____
Directions: _____ **Quantity:** _____ **Refills:** _____

PRESCRIBER INFORMATION

OFFICE/CLINIC NAME: _____ **ATTN:** _____

OFFICE ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **FAX:** _____

PRESCRIBER NAME _____

NPI: _____ **LICENSE:** _____ **DEA:** _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____

(substitution permissible if applicable)

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

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