ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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VIVITROL®
ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 7.15.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

www.commcarepharmacy.com
Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Always to Physician's Office □Alternate Site:(enter below)
Clinical Name:_____ Contact Name:_____
Address:_____ Phone:_____ Fax:_____
Suite:_____ City:_____ State:_____ Zip:_____

Patient's First Injection Date (Required by Insurance Plan):_____ Is patient restarting therapy? □Yes □No

Diagnostic Information: Please complete the diagnosis code(s) you would like to use by filling in the additional digits

Alcohol Dependence	**Opioid Dependence**
ICD-10	ICD-10
F10._____	F11._____
F10._____	F11._____
F10._____	F11._____
F10._____	F11._____
F10._____	F11._____
□Other:_____	□Other:_____

Patient has tried and failed the following medication(s):
_____
_____
_____

Patient's concurrent medication(s):
_____
_____
_____

Clinical Information (If Applicable)

For *OPIOID DEPENDENCE:*
Is the patient opioid-free for at least 7-10 days based on testing prior to initiation of Vivitrol? □Yes □No
Is the patient participating in a comprehensive management program that provides psychosocial support? □Yes □No

For *ALCOHOL DEPENDENCE:*
Has the patient abstained from alcohol in the outpatient setting prior to initiation of Vivitrol? □Yes □No
Is the patient actively consuming alcoholic beverages at this time? □Yes □No

Drug Name	Strength	Directions	Quantity	Refills
□Vivitrol®	□380mg vial	□Inject 380mg intramuscularly every 28 days □Other:_____	□1 vial (28 day supply) □3 vial (84 day supply)	
□Other				

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ □DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation):_____ Date:_____
□Please select if you would like the patient enrolled in a Manufacturer's Assistance Program

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