GIANNOTTO'S
SPECIALTY PHARMACY

Updated September 2023

VIVITROL REFERRAL FORM

195 First Avenue West | Newark, NJ 07107
Tel 973.482.8220 | Fax 844.587.9625

We are licensed in most states, please check our website for the most current list

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides

Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

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

☐ Yes ☐ No If the diagnosis is alcohol or drug dependence, will the patient abstain from using any alcohol or drugs?
☐ Yes ☐ No Will treatment be part of a comprehensive management program that includes psychosocial support?

ALCOHOL DEPENDENCE ICD-10 Codes

☐ **F10.29** Alcohol dependence with intoxication, unspecified
☐ **F10.21** Alcohol dependence, in remission
☐ **Other ICD-10** Code: _____
☐ **F10.20** Alcohol dependence, uncomplicated
☐ **F10.23** Alcohol dependence with withdrawal

For patients with ALCOHOL DEPENDENCE complete the following:

☐ Yes ☐ No Does the patient acute hepatitis/liver failure?
☐ Yes ☐ No Is the patient actively consuming alcoholic beverages at this time?
☐ Yes ☐ No Has the patient abstained from alcohol in the outpatient setting prior to the initiation of Vivitrol?

OPIOID DEPENDENCE ICD-10 Codes

☐ **F11.20** Opioid dependence, uncomplicated
☐ **F11.21** Opioid dependence, in remission
☐ **F11.23** Opioid dependence with withdrawal
☐ **Other ICD-10** Code: _____
☐ **F11.9** Opioid use, unspecified
☐ **F19.20** Other psychoactive substance dependence, uncomplicated
☐ **F19.21** Other psychoactive substance dependence, in remission

For patients with OPIOID DEPENDENCE complete the following:

☐ Yes ☐ No Is the patient receiving any opioid analgesics?
☐ Yes ☐ No Is the patient in acute opiate withdrawal?
☐ Yes ☐ No Is the patient opioid-free for at least 7-10 days based on testing prior to initiation of Vivitrol?

PRESCRIPTION

☐ **VIVITROL**
(naltrexone) 380mg single use kit (for intramuscular injection)

SIG: ☐ Inject 380mg IM 28 days
☐ Inject 380mg IM every _____ days
☐ Inject 380mg IM once every month
☐ Other_____

Dispense: ☐ 28-day supply ☐ 84-day supply
☐ Other _____ Refills _____

I, The patient signing below, giving my consent to my Fulfilling Pharmacy, Giannotto's Specialty Pharmacy that an agent of the pharmacy can perform Eligibility, benefit verification, send claims to my insurance in my behalf , inquire and assist in receiving Copay assistance and to communicate with my Healthcare Provider to coordinate the delivery of my prescribed medication for my next scheduled dose either at Office or at home. I understand that this serves as a patient authorization to BILL & ship, which means the Fulfilling Pharmacy may not contact me and/or my Designated Contact, prior to shipping medication as long as they have communicated with my Prescriber or their agents.

Patient Signature _____

Will your office be injecting Vivitrol?
☐ **Yes, all doses at our practice:**
☐ **No, Please visit provider indicated:**

Practice _____
Address _____
City, Street, ZIP _____
Phone: _____ Fax: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes Giannotto's Specialty Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.
PLEASE NOTE: Giannotto's Specialty Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

Please fax completed form to **Giannotto's** at **844.587.9625**

Visit **WWW.GIOPHARM.COM** for online fillable forms.