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Patient Intake Form-VIVITROL/SUBOXONE

3796 Howell Branch Road • Winter Park, FL 32792
Toll free: 866-699-8239 • Toll free fax 866-495-3304

TODAY'S DATE____________ DATE NEEDED____________

PATIENT INFORMATION

First:	Last:	M.I.:	☐Male ☐ Female
Date of Birth:	SSN:		Best Phone:
Address:	City:	State:	Zip:
Shipping Address (if different from home address):		Height:	Weight:

PRESCRIBER INFORMATION

First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION (PLEASE FAX COPIES OF FRONT AND BACK OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS)

Primary:	PCN:	BIN#	**Secondary:**	PCN:	ID#:
Phone:	ID#:	Group#	Phone:	BIN#	Group#
Prescription Drug Insurer:	Phone:		RxGrp#:	RxBIN#:	PCN/ID#:

CLINICAL INFORMATION (PLEASE ATTACH LABS)

Patient diagnosis: Please check all that apply

Alcohol Dependence	Opioid Dependence
☐ 303.00	☐ 304.00
☐ 303.01	☐ 304.01
☐ 303.90	☐ 304.02
☐ 303.91	☐ 304.03
☐ 303.92	
☐ 303.93	

Patient has tried and failed the following medications:

____

____

Please list any known allergies to medications or other substances:

____

____

☑ PRESCRIPTION

VIVITROL®

☐ 380mg x 1 unit   Inject 380mg IM q4 weeks

Refills_______

SUBOXONE®

☐ 2mg/0.5mg Sublingual film
☐ 4mg/1mg Sublingual film
☐ 8mg/2mg Sublingual film
☐ 12mg/3mg Sublingual film

Refills_______

DELIVERY ADDRESS

Facility Name: ____

Address: ____

City:________________________ST________Zip_________

Phone:___________________________Fax____________________

Office Contact____

ADDITIONAL INSTRUCTIONS

Please Deliver To: ☐ Patient's Home ☐ Dr.'s Office ☐ 1st dose to MD's office, remaining refills to patient's home	☐ Patient to pick up at pharmacy
Physician's Signature:	Date: