Vivitrol Referral Form
Prescription only valid if faxed.
Fax: (270) 251-3571

DUNCAN SPECIALTY PHARMACY

1522 Cuba Road
Mayfield, KY 42066
Phone: 270-247-3725
www.duncanrxcenter.com

PLEASE COMPLETE ALL FIELDS TO AVOID PROCESSING DELAYS

PRESCRIBER INFORMATION

Prescriber Name:
State License # DEA #
Prescriber Phone # Fax #
Facility Name: NPI #
Address:
City, State: Zip:

Staff Contact Name:
Staff Contact Phone #
Staff Contact Email:

INJECTION PROVIDER INFORMATION

Will your office/facility be injecting VIVITROL?
☐Yes, ALL doses
☐ No, the doses will shipped to and administered by the following:

Provider Name:
Phone #
Provider Address:
City, State: Zip:

PATIENT INFORMATION

Patient Name:
DOB: SSN: Gender: M F
Patient Address:
City, State: Zip:
Patient Preferred Phone Contact #
Patient Email Address:

Patient Diagnosis—*Please complete the diagnosis code(s) by filling in the additional digits.*

Alcohol Dependence	**Opioid Dependence**
ICD-10	**ICD-10**
F10.	F11.
F10.	F11.
F10.	F11.
F10.	F11.
F10.	F11.

PATIENT HAS TRIED & FAILED THE FOLLOWING MEDICATION(S):

PATIENT INSURANCE INFORMATION

Pharmacy Benefit Plan (PBM)—Required for Co-Pay card activation

*****ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD(S)*****

Payment Method: ☐Insured ☐Paying Out-of-Pocket

PBM Name and Phone #
Policyholder Name Relationship to Patient
Policy # Rx Grp:
RxPCN: Rx BIN#

PRESCRIPTION INFORMATION

- VIVITROL 380 mg x 1 unit inject 380 mg IM every 4 weeks or every 1 month

Refill _____ times (Complete refills to minimize interruption in 1 monthly VIVITROL therapy)

PROVIDER ATTESTATION

**Prescriber signature must be the same as the prescriber name above*

Prescriber's Signature:_____ Date:_____

By signing this form and utilizing our services, you are authorizing Duncan Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Revised 01/14/2021