

VIVITROL INJECTION ORDERS

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis

Patient Name:	DOB:
Allergies:	Patient Phone:

- Diagnosis:** Alcohol Dependency (_____)
- Opioid Dependency (_____)
- Other: _____ ICD-10: _____

J Code: J2315

VIVITROL ORDERS

Vivitrol Dose 380mg IM, given once every month

Number of Doses: _____ or 12 months

Other Orders:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	