



\*\*Physician Signature:

## **VIVITROL INJECTION ORDERS**

*REQUIRED INFORMATION**		
<ul> <li>□ This signed order form from the provider</li> <li>□ Patient demographics &amp; insurance information</li> <li>□ Clinical/Progress Notes, Labs, Tests supporting primary di</li> </ul>	agnosis	
Patient Name:	DOB:	
Allergies:	Patient Phone:	
Diagnosis:   Alcohol Dependency ()  Opioid Dependency ()  Other:  ICD-10:		
VIVITROL	ORDERS	
Vivitrol Dose ☐ 380mg IM, given once every month		
Number of Doses: or _ 12 months		
Other Orders:		
Physician Name:	Phone:	Fax:

Date: