Vivitrol (naltrexone)

Provider Order Form *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ F11.20 Opioid Dependence, uncomplicated
☐ F11.21 Opioid Dependence, in remission
☐ F10.20 Alcohol Dependence, uncomplicated
☐ F10.21 Alcohol Dependence, in remission
☐ Other: _____

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? ☐ Yes ☐ No

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?

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?

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

☐ Other: _____

Vivitrol Administration (Select one):

380mg single use carton

☐ Inject 380mg IM every 28 days
☐ Inject 380mg IM every_____ days
☐ Inject 380mg IM Once every month
☐ Other: _____

(Prescription valid for one year, unless otherwise indicated)

Dispense:

☐ 28-day Supply
☐ 84-day Supply
☐ Other: _____

Refill: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

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Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454