RECOVERY REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040

Patient Information

Patient Name: ______________________ DOB: ______________ Sex: ☐ M ☐ F

Phone: ______________ Cell Phone: ______________ Email Address: ______________

Address: ______________________ City: ______________ State: ______ Zip: __________

ICD-10 Diagnosis Code: ______________ Diagnosis: ______________________

Allergies (please note reaction): ______________________ ☐ Latex

Current Medications: (list here or attach a medication list): ______________________

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Comorbidities: (list here or attach a list): ______________________

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD

Prescription Information

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
☐ Vivitrol (naltrexone)	☐ Administer 380mg IM every 4 weeks	☐ 1 unit ☐ 3 units	
Other Medication Name:			

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Date of Last Administration: ______________

Prescriber Information

Prescriber Name: ______________________

State License #: ______________ DEA #: ______________ NPI: ______________

Additional Contact Person Name: ______________________

Group or Hospital: ______________________ Phone: ______________

Fax: ______________ Email Address: ______________________

Address: ______________________ City: ______________ State: ______ Zip: __________

Prescriber Signature:

______________________ Product Substitution Permitted ________ Date ______________________ Dispensed as Written ________ Date

Delivery Information

Ship to: ☐ Patient ☐ Prescriber/Clinic

☐ Pick up at an Albertsons Companies Pharmacy

Address: ______________________

Phone: ______________________

Date Medication Needed: ______________________

It's as simple as **caring.**

Ph. 800-834-8778
Fax 877-466-8040

E-Scribe Information:
Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.
Santa Fe Springs, CA 90670 • NCPDP 5617418 • NPI 1164451100