RECOVERY REFERRAL FORM

Albertsons Companies Specialty Care | MEDCART SPECIALTY PHARMACY | Jewel Osco | Albertsons | SAFEWAY | VONS | ACME | shaw's | star market | PAVILIONS | CARRS | Randalls | Tom Thumb

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): _____

_____

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

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
☐ Vivitrol (naltrexone)	☐ Administer 380mg IM every 4 weeks	☐ 1 vial	
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 | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy ☐ Pharmacist may administer

Date Medication Needed: _____