vitalcare of SAN ANGELO

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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:**	