

Fax to: 1-877-329-8484

Reimbursement Hotline: 1-800-848-4876, select option #2

TP ID# (Touchpoints Use Only) \_\_\_\_\_

**Prescriber Information**

Prescriber Name \_\_\_\_\_  
FIRST LAST  
 Prescriber Tax ID # \_\_\_\_\_ State License # \_\_\_\_\_  
 DEA # \_\_\_\_\_ Prescriber Phone # \_\_\_\_\_  
 Facility Name \_\_\_\_\_ Fax # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Staff Contact Name \_\_\_\_\_ Staff Contact Phone # \_\_\_\_\_  
 Staff Contact e-mail \_\_\_\_\_

**Injection Provider Information**

(Complete if referring to an Injection Provider/Facility other than your own)

Provider Name \_\_\_\_\_  
FIRST LAST  
 Provider Tax ID # \_\_\_\_\_ State License # \_\_\_\_\_  
 Provider Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
 Facility Name \_\_\_\_\_  
 Facility Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Staff Contact Name \_\_\_\_\_ Staff Contact Phone # \_\_\_\_\_  
 Staff Contact e-mail \_\_\_\_\_

**Will Your Office/Facility Be Injecting VIVITROL?** (Check ONE)

- Yes, ALL doses     No, please locate an Injection Provider (see page 2 for details)     No, I will refer to the Injection Provider/Facility above

Preferred Specialty Pharmacy (if applicable) \_\_\_\_\_  
 Special Shipping Instructions/Restrictions \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_  
FIRST LAST  
 Date of Birth \_\_\_\_\_ Gender  Male  Female  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Preferred Contact Phone # \_\_\_\_\_  
 Secondary Contact Phone # \_\_\_\_\_

**Patient Diagnosis**— Please Check All That Apply (See page 2 for Diagnosis Code Descriptions)

- |                                 |   |                                      |
|---------------------------------|---|--------------------------------------|
| <b>Alcohol Dependence</b>       | <b>Opioid Dependence</b>                                |                                      |
| <input type="checkbox"/> 303.00 | <input type="checkbox"/> 304.00                         | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> 303.01 | <input type="checkbox"/> 304.01                         |                                      |
| <input type="checkbox"/> 303.90 | <input type="checkbox"/> 304.02                         |                                      |
| <input type="checkbox"/> 303.91 | <input type="checkbox"/> 304.03                         |                                      |
| <input type="checkbox"/> 303.92 | <input type="checkbox"/> 304.7__ (fifth digit required) |                                      |
| <input type="checkbox"/> 303.93 |   |                                      |

Please list any known allergies to medications or other substances:  
 \_\_\_\_\_

**Insurance Status**

- Insured     Uninsured     Patient paying out-of-pocket

**Patient Insurance Information**

ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD(S), OR COMPLETE THE INSURANCE SECTION BELOW.

**PRIMARY INSURANCE**

Carrier Name \_\_\_\_\_ Carrier Phone # \_\_\_\_\_  
 Policyholder Name \_\_\_\_\_ Policy # \_\_\_\_\_  
 Policyholder Employer Name \_\_\_\_\_  
 Group ID # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Insurance Type:  HMO     PPO

**SECONDARY INSURANCE**

Carrier Name \_\_\_\_\_ Carrier Phone # \_\_\_\_\_  
 Policyholder Name \_\_\_\_\_ Policy # \_\_\_\_\_  
 Policyholder Employer Name \_\_\_\_\_  
 Group ID # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**PHARMACY BENEFIT PLAN**

Pharmacy Benefit Manager (PBM) Name \_\_\_\_\_  
 PBM Phone # \_\_\_\_\_  
 Policyholder Name \_\_\_\_\_ Policy # \_\_\_\_\_  
 Policyholder Employer Name \_\_\_\_\_  
 Group ID # \_\_\_\_\_ Rx BIN # \_\_\_\_\_

**Prescription Information** (Required for patient to receive ongoing monthly VIVITROL therapy.)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
FIRST LAST  
 VIVITROL 380 mg x 1 unit    Inject 380 mg IM q4 weeks or q1 month    Provider State License # \_\_\_\_\_  
 3 month supply    Refill \_\_\_\_\_ times (Complete the number of refills to minimize interruption in monthly VIVITROL therapy for this patient.)

**Prescriber Attestation**

Prescriber's Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

By signing above, I verify that the information provided in this Touchpoints enrollment form is complete and accurate to the best of my knowledge. I understand that Alkermes reserves the right at any time and for any reason, without notice, to modify this Touchpoints enrollment form or to modify or discontinue any services or assistance provided through Touchpoints. Finally, I authorize Alkermes, United BioSource Corporation, Armada Health Care L.L.C. and Opus Health as my designated agents to use and disclose my patient's health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through Touchpoints, to forward the above prescription, by fax or other mode of delivery, to a pharmacy for fulfillment, and (as applicable) to assess my patient's eligibility for co-pay assistance.

**Request for VIVITROL Value Program Co-Pay Assistance**

**\$0 CO-PAY UP TO \$500/MONTH FOR ELIGIBLE PATIENTS\***

The \$0 CO-PAY Program is only available for patients with **COMMERCIAL INSURANCE**.

**Yes, I would like to participate in the \$0 CO-PAY Program. I certify that I meet the eligibility criteria below.**

\* Eligibility for Alkermes-sponsored co-pay assistance: Offer valid for prescriptions for alcohol dependence or for the prevention of relapse to opioid dependence, following opioid detoxification. Patients must be at least 18. Offer not valid for prescriptions purchased under Medicaid, Medicare, or any federal or state healthcare program, including any state medical or pharmaceutical assistance program. Offer not valid in Massachusetts. Offer not valid for cash pay patients. Void where prohibited by law, taxed or restricted. Alkermes, Inc. reserves the right to rescind, revoke or amend these offers without notice.

**Injection Provider Selection Information (as applicable)**

If you have requested injection services for your patient, Touchpoints will provide a selection of several injectors based on geographic proximity to your patient's address listed on the enrollment form (from closest to farthest from such address).

These injection providers are listed in the **VIVITROL Assisted Recovery Provider Locator\*** (posted on [www.VIVITROL.com](http://www.VIVITROL.com)).

**PLEASE NOTE:** These options will normally be provided both in writing and via fax with a request for fast response so that coordination can be accomplished. If, after repeated attempts to contact you, we have not received a response, we will contact the geographically closest injection services provider to help coordinate injection services for your patient.

\* Enrollment in the Locator is voluntary and free of charge and, along with the provider-specific information in the Provider Locator, is based on healthcare provider responses. Alkermes has not independently verified the qualifications of any healthcare provider included in the Locator. Alkermes disclaims all warranties, either express or implied, including but not limited to the implied warranties of merchantability and fitness for particular purpose. Alkermes shall in no event be liable to you or to anyone for any decision made or action taken by you in reliance on information.

**Diagnosis Code Descriptions**

**Alcohol Dependence**

Acute alcoholic intoxication in alcoholism unspecified drinking behavior (303.00)  
 Acute alcoholic intoxication in alcoholism continuous drinking behavior (303.01)  
 Other and unspecified alcohol dependence unspecified drinking behavior (303.90)  
 Other and unspecified alcohol dependence continuous drinking behavior (303.91)  
 Other and unspecified alcohol dependence episodic drinking behavior (303.92)  
 Other and unspecified alcohol dependence in remission (303.93)

**Opioid Dependence**

Opioid type dependence unspecified use (304.00)  
 Opioid type dependence continuous use (304.01)  
 Opioid type dependence episodic use (304.02)  
 Opioid type dependence in remission (304.03)  
 Combination of opioid type drug with any other drug dependence (304.7\_\_) (fifth digit required)



### Patient Authorization for Use/Disclosure of Health Information

By signing below, I **authorize** my prescribing physician, the healthcare provider designated to administer VIVITROL to me (“Administering HCP”), one or more network specialty pharmacies,\* Cardinal SPS, United BioSource Corporation, Group DCA, Opus Health, Nowspeed, Healthtalker, Evoke, Armada Health Care L.L.C. and Alkermes **to use and disclose** to each other and to my Designee(s), listed below, my medical or other information set forth on the first page of this form, including information about my treatment with VIVITROL (taken together, “Information”) **for the specific purposes** of ordering, delivering and administering VIVITROL, obtaining payment from my Health Plan(s), conducting reimbursement verification, *providing me with educational and therapy support services by mail, e-mail and/or telephone and referring me to, or determining my eligibility for, other programs, foundations or alternative sources of funding or coverage to help me with the costs of VIVITROL. I understand that support services may include product information materials and treatment reminders that may be of interest to me.* I understand that the parties to which I have authorized disclosure in this authorization may not be subject to applicable federal and state privacy laws and that my Information could be subject to re-disclosure. If my prescribing physician or Administering HCP is providing me treatment at a federally assisted program under 42 CFR Part 2, my Information may not be used or further disclosed other than as provided in this authorization.

I understand that signing this authorization is voluntary and if I do not sign this authorization it will not affect my ability to obtain treatment from my prescribing physician or obtain insurance or insurance benefits. I understand, however, *that if I do not sign this authorization, I will not be eligible to receive the educational and support services and other services described above.* I understand I have the right to receive a copy of this authorization after I sign. I understand that I may see a copy of the information described in this authorization if I request to do so.

I may withdraw this authorization at any time by mailing or faxing a written request to Touchpoints Reimbursement Support; 4511 Singer Court; Suite 210; Chantilly, VA 20151 or by calling 1-800-VIVITROL. Withdrawal of this authorization will end further uses and disclosures of my Information by the parties identified in this authorization except to the extent those uses and disclosures have been made in reliance upon this authorization and as permitted by applicable law. This authorization expires five years from the date indicated below unless I withdraw it earlier.

In addition, my Designee(s), listed below, is hereby authorized to receive administrative information related to my treatment, such as appointment reminders, and to make decisions on my behalf—for which I will remain liable—regarding delivery of VIVITROL. Alkermes is not liable for any decision(s) made by the Designee(s) or actions taken in reliance on such Designee(s) decisions.

Designee Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Alternate Designee Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Patient’s Signature† \_\_\_\_\_ Date of Signature† \_\_\_\_\_

Parent/Guardian/Legal Representative’s Signature† \_\_\_\_\_

Authority/Relationship to Patient \_\_\_\_\_

\*Network Specialty Pharmacies include Accredo®, Aetna Specialty Pharmacy®, CVS/Caremark®, CuraScript®, Walgreens Specialty Pharmacy® and other specialty pharmacies providing similar services.

†If patient is a minor without capacity to act alone under state law, signature of patient and parent/guardian/legal representative is required.

Accredo is a registered trademark of Accredo Health Group, Inc, a wholly owned subsidiary of Medco Health Solutions, Inc.  
 Aetna Specialty Pharmacy is a registered trademark of Aetna, Inc.

**PLEASE SEE VIVITROL FULL PRESCRIBING INFORMATION INCLUDING BOXED WARNING AT [www.vivitrol.com/pdf\\_docs/prescribing\\_info.pdf](http://www.vivitrol.com/pdf_docs/prescribing_info.pdf)**