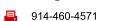


175MemorialHighway.Suite1-1 NewRochelle,NY 1080

C	914-460-489
\checkmark	fuse@fuseinfusion.com





Ok the switch to biosimilar if insurance formulary prefers

		PATIENT INFORMATION		
Name:		DOB:	SEX: M □ F □	
Allergies:		Date of Referral:		
		PHYSICIAN INFORMATION		
Physician Name*:		Practice Name:	I	
Address:		Office Contact*:	Office Contact*:	
Phone: Fax: Email (for updates):				
		REFERRAL STATUS		
□New Referral □	Referral Renewal \(\sigma\)	Medication/Order Change \Box Benefits Verificat	ion Only	
Prescriber	Information			
Date	Time	Date medication needed		
Prescriber's first name	criber's first name Last name			
rescriber's title If NP or PA, under direction of Dr				
Office address				
Office contact and title_				
Office contact phone number Office contact e-mail				
Office clinic/institution name Clinic/hospital affiliation				
City		State	Zip	
Phone	Fax	NPI #	License #	
Deliver product to: Office	e Clinic			
Clinical In	formation			
Primary ICD 10 code:		Has the patient been on therapy before? Yes I	Date of last dose N	
Please provide clinical do			Date of fast dose N	
•	•	e: II the patient abstain from using alcohol or drugs	2 Voc. No.	
-				
	-	ement program that includes psychosocial suppo		
•		Receiving opioid analgesics • With current physi	•	
Is in acute opiate withdWho has acute hepatiti		kone challenge test or has a positive urine screen	for opioids	
Medication	Strength/Formulation	Directions	Quantity/Refills	
☐ Vivitrol [®] (naltrexone)	380mg single use	☐ Inject 380mg IM every 28 days	Dispense:	
	carton	☐ Inject 380mg IM every days	□ 28-day supply	
		uays	□ 84-day supply	
			☐ Other	
			Refills————	
	11 / 3 .	cillary supplies such as needles, syringes, sterile	Cond guantity (Cond.	
Prescriber, please che water, etc. as neede	Send quantity sufficient for medication days supply			
water, etc. as needed	a to dominioter the therap	~1		
ORDERING PROVIDE	ER			
Signature X		Date Provider		
Phone Fax	·			

Date: _____