

Vivitrol[®]
(naltrexone for extended-release
injectable suspension) 380 mg/vial

VIVITROL[®] Buy and Bill Quick Start Guide

Alkermes[®]

Understanding the **Buy and Bill** Process



Purchase/ Setup



Verify Coverage/ Prescribe



Administer



Billing And Reimbursement

- **Establish** an account with specialty distributor
- **Purchase** product from specialty distributor
- Office **receives** VIVITROL® and stores appropriately
- **Enroll** with IQVIA (formally known as Opus) to become a VIVITROL Co-pay Savings Program participant
- **Verify** patient benefits
- Provider **prescribes** VIVITROL
- **Confirm** Criteria for Use are met, if needed (PA)
- Patient is **injected** with VIVITROL
- **Submission** of claim form to payer (CMS-1500 form or CMS-1450 [UB-04] form)
- EOB and payment are **received** from payer for VIVITROL (J2315) and injection (96372) 4-6 weeks after submission
- After EOB is **received**, complete Co-pay Savings Program Payment Form for Healthcare Providers and send with EOB to IQVIA (formally known as Opus)
- **Reimbursement** for patient out-of-pocket costs is sent from IQVIA (formally known as Opus) 2-4 weeks after submission

Buy and Bill reduces time between prescribing and administering VIVITROL by allowing providers to have the product on hand, which may help streamline the treatment journey

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VIVITROL® Buy and Bill Resources

Vivitrol2gether® Patient Enrollment Form

Patient Enrollment Form

COMPLETE ALL FIELDS TO AVOID PROCESSING DELAYS. PRESCRIPTION ONLY VALID IF FAXED. FAX COMPLETED FORM TO: 1-877-329-8484. QUESTIONS? CALL 1-800-VIVITROL (1-800-848-4876), 9AM-8PM (EST).

Prescriber Signature(s) (page 1) and Patient Signature(s) (page 2) required.

1. PLEASE SELECT PROGRAM OFFERING(S) THAT BEST MEET(S) YOUR PATIENT'S NEEDS

Vivitrol2gether sends prescription to pharmacy*

Transition of Care Services*

Benefits Verification

Buy & Bill

*Includes Transition of Care, Appointment Reminders, and Benefits Verification as applicable.

2. PRESCRIBER OR FACILITY INFORMATION

Prescriber (First) (Last)

Tax ID # State License #

NPI # PTAN #

Facility Name PA # (if obtained)

Facility Phone # Fax #

Address

City State ZIP Code

Staff Name Staff Phone #

Staff Email Address

Additional Information

3. PATIENT INFORMATION

Name (First) (Middle Initial) (Last)

Date of Birth Gender Male Female

Address

City State ZIP Code

Mobile Phone # Home Phone #

Phone Instructions (Best Number)

Email Address

→ INSTRUCT PATIENT TO LIST ALTERNATE CONTACTS ON PAGE 2.

4. PATIENT DIAGNOSIS—(A list of codes can be found on page 3, section 13)

Please check primary diagnosis: Alcohol Dependence Opioid Dependence

Patient has tried and failed the following medication(s):

ICD-10

FTL

Please list any known allergies to medications or other substances: No Known Drug Allergies (NKDA)

FTL

Patient's concurrent medications:

FTL

With you along the way. (naltrexone for extended-release injectable suspension) 380 mg/vial

5. TRANSITION OF CARE COORDINATION

If the office provides all injections, slip to section 6

Patient Estimated Discharge Date (if applicable): / /

Select Option(s) That Apply:

Office will provide the **FIRST** injection only **QB**

Office provides **NO** injections

Patient will continue with current provider, but injections will be administered elsewhere

Select Option(s) That Apply:

Vivitrol2gether sends prescription to pharmacy*

Patient requires assistance from Vivitrol2gether to locate a new provider or injection site **QB**

Patient will transition to/receive injections at provider below:

Provider/Injection Site Name Phone #

Address

6. PATIENT INSURANCE INFORMATION

A. Payment Method Insured Paying out-of-pocket

B. ATTACH COPY OF PATIENT'S (1) MEDICAL, (2) PHARMACY, AND (3) SECONDARY INSURANCE CARDS AS APPLICABLE (BOTH SIDES)

C. IF YOU DO NOT ATTACH INSURANCE CARD, COMPLETE SECTION BELOW.

Insurance Type Commercial Medicaid Medicare Other

Insurance Name

Policyholder Name PA # (if obtained)

Relationship to Patient Insurance Phone #

Policyholder Employer Name

Policy # Group ID #

Policy Type HMO PPO Other

PHARMACY BENEFIT PLAN (PBM)

PBM Name PBM Phone #

Member Name Member #

Relationship to Patient

Member Employer Name

Rx Group # Rx BIN # Rx PCN #

Co-pay Card Number (if obtained)

7. PRESCRIPTION INFORMATION

Not required for patient transition support from hospital setting

Patient Name (Required - Please Print Full Name)

VIVITROL 380 mg x 1 unit Inject 380 mg IM every 4 weeks or every 1 month

Provider State License # Refill times

(Complete refills to minimize interruption in monthly VIVITROL therapy)

By signing below, I verify that the therapy above is medically necessary. I authorize Alkermes, its affiliates, representatives and agents as my designated agents to forward the prescription, by fax or by any means allowed under applicable law, to a pharmacy for fulfillment.

Dispense as Written or Substitution Permitted

Prescriber Signature Date

Pharmacial may repeat Prescriber Signature Date

*Prescriber Signature must be the same as the Prescriber Name. No stamps allowed.

8. PRESCRIBER ATTESTATION

By signing below, I verify that the information provided in this Vivitrol2gether enrollment form is complete and accurate to the best of my knowledge. I understand that Alkermes, Inc., reserves the right at any time and for any reason, without notice, to modify this Vivitrol2gether enrollment form or to modify or discontinue any services or assistance provided through Vivitrol2gether. Finally, I authorize Alkermes, its affiliates, representatives and agents 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 Vivitrol2gether and (as applicable) to assess my patient's eligibility for co-pay assistance.

Prescriber Signature Date

VIV-006321 PLEASE SEE IMPORTANT SAFETY INFORMATION ON PAGE 4. PLEASE SEE PRESCRIBING INFORMATION AND MEDICATION GUIDE, OR VISIT VIVITROLHCP.COM. PLEASE REVIEW MEDICATION GUIDE WITH PATIENTS. PAGE 1

Contact Information

Buy and Bill via Provider Pricing Program

Besse Medical

Phone: 1-800-543-2111

Fax: 1-800-543-8695

<https://www.besse.com/create-an-account>

Henry Schein Medical

Phone: 1-800-772-4346

Fax: 1-800-329-9109

<https://www.henryschein.com/medical>

CuraScript SD

Phone: 1-877-599-7748

Fax: 1-800-862-6208

<https://www.curascriptsd.com/newaccountforms>

VIVITROL Co-pay Savings Program

Phone: 1-877-838-3836

Fax: 1-908-548-0968

<https://vivitrolbuyandbillcopay.opushealth.com>

Vivitrol2gether Patient Support Services

Phone: 1-800-VIVITROL

(1-800-848-4876),

Monday-Friday 9am-8pm (ET)



To request Benefit Verification and/or Transition of Care Services, be sure to **fully complete the Vivitrol2gether Patient Enrollment Form and check the Buy and Bill box.**

Get the form from your Alkermes representative.

Buy and Bill Implementation Checklist

Consider using the following as a guide to identify whether your facility is prepared to implement Buy and Bill



Do your payer contracts accommodate Buy and Bill?



Is there a resource in your office who will handle Buy and Bill?



Is there a process for billing the payer and managing product inventory?



Did you establish an account with a specialty distributor?



Have you enrolled in the VIVITROL® Co-pay Savings Program with IQVIA (formally known as Opus)?

If you would like additional information, please contact an [Alkermes representative](#)



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