Provider Authorization & Confidentiality Agreement

(denotes required information)*

This form must be completed by the Prescriber or Medical Director at the facility requesting access to the Vivitrol2gether℠ Patient Support Services Portal. **PLEASE PRINT ALL INFORMATION CLEARLY.**

Facility Information

*Prescribing Physician Name: _____

*Prescriber State License Number: _____ *Prescriber Email: _____

*Facility Name: _____

*Facility Address: _____

*City: _____ *State: _____ *Zip: _____

*Facility Phone Number: _____

Medical Director Name (if applicable): _____

I, _____, hereby request access to the Vivitrol2gether℠ Patient Support Services Portal ("Portal"). I certify that I have submitted patient enrollment forms to Vivitrol2gether℠ Patient Support Services and that I am managing the patient and type of data that resides within the Portal for the patients I have enrolled.

I understand that the information contained in the Portal constitutes protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA).

I understand that information contained in the Portal is provided for the purposes consented by the patient in writing to Vivitrol2gether℠, specifically: ordering, delivering and administering VIVITROL® (naltrexone for extended-release injectable suspension), obtaining payment from patient's Health Plan(s), conducting reimbursement verification, providing patient with educational and therapy support services by mail, e-mail and/or telephone and referring the patient to, or determining patient's eligibility for, other programs, foundations or alternative sources of funding or coverage to help the patient with the costs of VIVITROL.

*Signature: _____ *Date: _____
Note: Signatory must be prescriber or Medical Director M M / D D / Y Y Y Y

*Check one: ☐ Prescriber ☐ Medical Director

Email notification preference (pick one)

*Check one: ☐ Prescriber ☐ Staff Member ☐ Both

Please fax the completed form to 1-781-207-8540.
To request access for additional staff members, please complete and fax the following page.

Vivitrol2gether™
M-F, 9:00 AM to 8:00 PM ET
1-800-VIVITROL (1-800-848-4876)
Fax: 1-877-FAX-VIVI (1-877-329-8484)

Additional Staff Member Access

I request the following staff members to be provided access to my enrollments in the Portal. I have authorization under applicable state or federal privacy laws to disclose information to the individual(s) below.

Staff Member

First Name: ______________________________________

Last Name: _______________________________________

Facility Address[i]: ____

City: _______________________ ST: ____ Zip: __________

Email[ii]: ____

☐ Include all facilities for this prescriber

Staff Member

First Name: ______________________________________

Last Name: _______________________________________

Facility Address[i]: ____

City: _______________________ ST: ____ Zip: __________

Email[ii]: ____

☐ Include all facilities for this prescriber

Staff Member

First Name: ______________________________________

Last Name: _______________________________________

Facility Address[i]: ____

City: _______________________ ST: ____ Zip: __________

Email[ii]: ____

☐ Include all facilities for this prescriber

Staff Member

First Name: ______________________________________

Last Name: _______________________________________

Facility Address[i]: ____

City: _______________________ ST: ____ Zip: __________

Email[ii]: ____

☐ Include all facilities for this prescriber

[i] Staff members will be provided access to view enrollments treated at the corresponding facility address entered above. If a staff member needs to see enrollments treated at multiple facilities, please list all facility addresses that apply. If the staff member needs to see enrollments for ALL facilities where the physician prescribes, check **"Include all facilities for this prescriber".**

[ii] All email addresses must be unique.

Please fax the completed form to 1-781-207-8540.

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Fax: 1-877-FAX-VIVI (1-877-329-8484)