touchpoints® Support Services — PATIENT ENROLLMENT

Prescription only valid if faxed 9013880407

FAX COMPLETED FORM TO: ~~1-877-329-8484~~ mike

PLEASE COMPLETE ALL FIELDS TO AVOID PROCESSING DELAYS

TOUCHPOINTS PHONE: 1-800-848-4876

TP ID# (TOUCHPOINTS USE ONLY): _____

PRESCRIBER INFORMATION

Prescriber Name*

Prescriber Tax ID # 202620190 DEA#

State License # NPI #

Prescriber Phone # 8657692600 Fax # 8657692616

Facility Name Westbrook Medical Center

Address 930 Adell Ree Park Lane

City Knoxville State Tn Zip Code 37909

Staff Contact Name Lucy

Staff Contact Phone # 865769260 Staff Contact E-mail lucy.westbrook medical@gmail.com

INJECTION PROVIDER INFORMATION

Will your office/facility be injecting VIVITROL?

☒ Yes, ALL doses

☐ No, please locate an Injection Provider or refer to Provider below

Provider Name

Provider Address

Provider Phone #

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

Home Phone # Mobile Phone #

Best Day to Call ☐ M ☐ T ☐ W ☐ TH ☐ F

Best Time to Call ☐ Morning ☐ Afternoon ☐ Evening

Email Address SSH

INSTRUCT PATIENT TO LIST ALTERNATE DESIGNEE OR CONTACTS ON PAGE 2.

PATIENT INSURANCE INFORMATION

Payment Method ☐ Insured ☐ Paying out-of-pocket

ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD(S).

IF NOT AVAILABLE, COMPLETE SECTION BELOW.

PRIMARY INSURANCE

Insurance Type ☐ HMO ☐ PPO ☐ Medicaid ☐ Medicare

Carrier Name

Policyholder Name

Relationship to Patient Carrier Phone #

Policyholder Employer Name

Policy # Group ID #

PHARMACY BENEFIT PLAN (PBM)

PBM Name

Policyholder Name

Relationship to Patient PBM Phone #

Policyholder Employer Name

Policy # Group ID #

Rx BIN #

PATIENT DIAGNOSIS–Please check all that apply (See page 3 for Diagnosis Code Descriptions)

Alcohol Dependence		Opioid Dependence		
☐ 303.00	☐ 303.91	☐ 304.00	☐ 304.03	☐ 304.72
☐ 303.01	☐ 303.92	☐ 304.01	☐ 304.70	☐ 304.73
☐ 303.90	☐ 303.93	☐ 304.02	☐ 304.71	☐ Other _____

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

Please list any known allergies to medications or other substances:

☐ Check if patient has concurrent medications

Patient's concurrent medications:

PRESCRIPTION INFORMATION

Patient Name Date

VIVITROL 380 mg x 1 unit Inject 380 mg IM every 4 weeks or every 1 month Provider State License #

Refill 11 times (Complete refills to minimize interruption in monthly VIVITROL therapy)

By signing below, 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, LLC, 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.

PROVIDER ATTESTATION

* Prescriber signature must be the same as the prescriber name above

Prescriber's Signature _____

(If applicable) Prescriber's Signature (No Stamps Allowed)

Dispense as Written

Substitution Permitted

Date of Signature

PLEASE SEE IMPORTANT SAFETY INFORMATION ON PAGE 4. PLEASE SEE PRESCRIBING INFORMATION AND MEDICATION GUIDE, OR VISIT VIVITROL.COM. PLEASE REVIEW MEDICATION GUIDE WITH PATIENTS.

Vivitrol® (naltrexone for extended-release injectable suspension)

PATIENT REPRESENTATIVE

By signing below, I authorize my Designee(s), listed below, 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® (naltrexone for extended-release injectable suspension). Alkermes is not liable for any decision(s) made by the Designee(s) or actions taken in reliance on such Designee(s) decisions.

Please list any Designees authorized to receive administrative information related to my treatment:

Designee Name (1)	Relationship	Phone #
Designee Name (2)	Relationship	Phone #
Patient's Signature	Date of Signature	

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing below, **I authorize**: **1.** my prescribing physician, **2.** the healthcare provider designated to administer VIVITROL to me ("Administering HCP"), **3.** one or more network specialty pharmacies†, United BioSource Corporation, Intouch Solutions, OPUS Health, Armada Health Care, LLC, and **4.** Alkermes **to use and disclose** to each other and to my Designee(s), listed above, 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: **1.** ordering, delivering, and administering VIVITROL, **2.** conducting reimbursement verification and obtaining payment from my Health Plan(s), **3.** providing me with educational and therapy support services by mail, text-messaging, e-mail, and/or telephone and **4.** 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. **Information May Be Further Disclosed:** I understand that INFORMATION disclosed pursuant to this authorization could be re-disclosed by a recipient and may no longer be protected by federal privacy law (HIPAA). **For California Residents:** California law prohibits the person receiving your health information from making further disclosure of it, unless another authorization for such additional disclosure is obtained from you or unless such disclosure is specifically required or permitted by law.

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, support or other services described above. I understand I have the right to receive a copy of this authorization after I sign. I understand that the disclosure of my Information may result in remuneration to one or more network specialty pharmacies. 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, 1670 Century Center Parkway, Memphis, TN 38134 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.

Patient's Signature X	Date of Signature
Parent/Guardian/Legal Representative's Signature§	Authority/Relationship to Patient

☐ ***(Check if "yes")*** **I would like to receive co-payment assistance from Alkermes.** I certify that I am at least 18 years old, I am being treated for opioid dependence after detox or alcohol dependence and that my VIVITROL prescription will NOT be purchased under Medicaid, Medicare, TRICARE®, or any federal or state healthcare program, including any state medical or pharmaceutical assistance program.‡

† See page 3 for a list of Network Specialty Pharmacies.

‡ **Eligibility for Sponsored Co-pay Assistance**: Offer valid for prescriptions for FDA-approved indications. Patients must be at least 18. Offer not valid for prescriptions purchased under Medicaid, Medicare, TRICARE® or any other federal or state healthcare program, including any state medical or pharmaceutical assistance program. Void where prohibited by law, taxed or restricted. Alkermes, Inc. reserves the right to rescind, revoke or amend these offers without notice.

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

PLEASE SEE IMPORTANT SAFETY INFORMATION ON PAGE 4. PLEASE SEE PRESCRIBING INFORMATION AND MEDICATION GUIDE, OR VISIT VIVITROL.COM. PLEASE REVIEW MEDICATION GUIDE WITH PATIENTS.

W

ESTBROOK MEDICAL CENTER,PLLC
930 ADELL REE PARK LANE
KNOXVILLE, TN 37909
865/769-2600

VIVITROL (NALTREXONE) TREATMENT INFORMED CONSENT

(Please initial)

1)	I understand that if I take opiates after having the Vivatrol injection, I will NOT feel their effects by getting high or having pain control, BUT I COULD HAVE ACCIDENTAL OVERDOSE AND DIE.	
2)	I understand that I need to be opiate free for 7-10 days including legal painkiller such as Oxycontin, Hydrocodone, Morphine, Vicodin, Fentanyl, Duragesic, or others, or illegal opiates such as heroine.	
3)	I understand that I need to be free from using Methadone for a minimum of two (2) weeks or the time decided by my provider at Westbrook Medical.	
4)	I understand that if I've been detoxing using Buprenorphine (Suboxone/Subutex), I need to be off of it for at least 7-10 days, and not use any other opiates during this time.	
5)	I understand that once injected, Vivitrol cannot be removed and will be deposited in muscle tissue for up to one month.	
6)	I understand that I may experience acute opiate withdrawal symptoms if I still have opiates in my system, even if I've waited two (2) weeks. Opiate withdrawal symptoms include runny nose, anxiety, nausea, vomiting, abdominal pain, diarrhea, muscle aches and pain, which may be extremely severe in some cases.	
7)	I understand that I may experience symptoms such as nausea, vomiting and/or abdominal pain, if I consumed alcohol less than one week before the first Naltrexone dose.	
8)	I understand that if I sustain an injury which may require treatment with opiates, it may be more difficult to treat my pain because of Naltrexone blocking the brain's opiate receptors.	
9)	I understand that if I attempt to override the opiate receptor blockage with opiates, I run the risk of ACCIDENTAL OVERDOSE OR DEATH.	
10)	I understand that I should not be on Naltrexone if I have acute infectious hepatitis.	
11)	I understand that the risks of being on Naltrexone during pregnancy are unknown, and therefore it is not recommended. I further understand that it my responsibility to have an adequate birth control method.	
12)	I understand that Naltrexone treatment is not a substitute for recovery and that I must participate in counseling in order to obtain the maximum benefit from treatment with this injection. I also understand that I must bring proof of attendance for all counseling appointments.	
13)	I understand that potential side effects are nausea, vomiting, headache, dizziness and tiredness, and redness, swelling, pain and discomfort at the injection site.	
14)	I understand that Vivitrol is currently indicated and approved by the FDA for alcohol and opioid dependency.	
15)	I have been explained all the points above and have had the opportunity to ask questions.	
16)	I understand that I will have blood tests done to assess the effects of opiate use on my body. These tests may include HIV, Hepatitis, lipid panel, etc.	

I, _____, have been informed of the above issues regarding treatment with Vivitrol (Naltrexone injection).

_____ _____
Patient's Signature Date

_____ _____
Staff's Signature Date

I give my permission for Westbrook Medical Center staff to discuss any aspect of my care with my counselor. This will remain in effect until revoked by written consent.

_____

Patient Printed Name

_____

Patient Signature

_____

Date

_____

Witness Signature

REGISTRATION FORM

Date_____

Patient Name_____
Last First Middle Suffix
Sex: Male_____ **Female**_____ **Patient's Social Security Number**_____
Birth date _____**Single** ___ **Divorced** ___ **Married** ___ **Widowed** ___ **Separated** ___

Home Street Address_____
City_____**State**_____**Zip**_____
Home Phone (_____**)**_____ **Cell Phone (**_____**)**_____
Cell Phone Company_____ **email address** _____
Name of Primary Care Physician_____ **Phone #**_____
Referral Source_____ **Patient's Driver's License Number**_____
PHARMACY **Pharmacy Name, Address, and Phone Number** _____
_____

EMPLOYER OF PATIENT
(or Guardian if patient is minor)
Company Name_____
Address_____
City _____**State** _____**Zip**_____
Occupation _____ **Phone Number(**_____**)**_____

Circle appropriate answer:
Race: American Indian Asian Black Caucasian Other Declined
Ethnicity: Hispanic Non-hispanic Declined

Primary Language Spoken_____

Name of Parent or Guardian (if patient is a minor)_____
Date of birth of Guardian_____ **SSN of Guardian** _____
Driver's License # of Guardian_____

SPOUSE OF PATIENT
(or Guardian if patient is minor)
Name_____
Birthdate _____**Social Security Number**_____
Employer Name_____
Address_____
City_____**State**_____**Zip**_____**Phone**_____

REASON FOR VISIT
Condition related to: Illness_____ **Well visit**_____**Accident**_____
Other_____ **Date of Accident, if applicable**_____

INSURANCE INFORMATION
Insurance Company_____
Insured Name _____**Relationship to Patient**_____
Group or Policy Number_____ **ID #**_____

Westbrook Medical Center
7328 Middlebrook Pike
Knoxville, TN 37909

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ **DOB**_____

Review of Systems: (Check all that apply)

Head & Neck
___ Eye Disease
___ Double vision
___ Blurred vision
___ Prior-Ear Surgery
___ Ear Ache
___ Hearing loss
___ Dizziness
___ Ringing in ears
___ Nasal Obstruction
___ Nosebleeds
___ Nasal Discharge
___ Altered sense of smell
___ Sinusitis
___ Nasal Polyps
___ Snoring
___ Excessive sleepiness
___ Facial pain
___ Pain with chewing
___ Recent dental work
___ Mouth sores
___ Lumps in the neck
___ Allergies

Respiratory System
___ Hoarseness
___ Chronic cough
___ Throat clearing
___ Heart Burn
___ Regurgitation
___ Spitting up blood
___ Shortness of breath
___ Wheezing
___ Asthma
___ Chronic bronchitis
___ Chest Pain
___ Emphysema
___ Tuberculosis
___ Lung cancer

Neurologic
___ Headaches
___ Head injury
___ Numbness or tingling
___ Transient black-outs
___ Transient vision loss
___ Seizures
___ Strokes

General
___ Night Sweats
___ Fevers
___ Skin diseases
___ Arthritis
___ Bleeding Disorder
___ Easy Bruisability
___ HIV infection or AIDS
___ Psychiatric Diseases

Gastrointestinal
___ Difficult swallowing
___ Pain on swallowing
___ Diarrhea
___ Constipation
___ Jaundice
___ Liver disease
___ Hepatitis
___ Kidney Disease
___ Bloody stools
___ Diverticulosis
___ Gall bladder disease
___ Heartburn or ulcers

Cardiovascular
___ Hypertension
___ Heart disease
___ Angina
___ Swelling of the ankles
___ Heart surgery
___ Angioplasty
___ Pacemaker
___ Anemia

Endocrine
___ Diabetes
___ Heat/cold intolerance
___ Thyroid imbalance
___ Menstrual disorders

Urologic
___ Difficulty on urination
___ Frequent urination
___ Blood in the urine
___ Prostate problems

Other
_____

Past and present medical problems:

_____
_____
_____
_____
_____
_____
_____

Previous surgeries and dates (month/year)

_____
_____
_____
_____
_____
_____
_____

List all current medications and dosages (including OTC):

_____
_____
_____
_____
_____
_____
_____

Do you smoke?
___Yes ___ No
If yes, how much ?_____

Do you drink alcohol?
___Yes ___ No
If yes, how much ?_____

Please list all allergies: (medications, inhalants, foods, contact allergies) _____
_____

Patient Signature_____ **Date**_____

ASSIGNMENT – AUTHORIZATION & LIEN

I hereby irrevocably authorize and direct my insurance company, my attorney, and/or any third party payers to pay directly to the provider, Westbrook Medical Center, PLLC, all sums of money due for any and all services rendered to me (or a minor child for which I m responsible) by reason of accident, illness or any and all reasons. I further direct said insurance company, attorney, or third party payer to withhold such sums from any payment, including but not limited to health and accident benefits, disability benefits, workers' compensation benefits, medical payment benefits, no fault benefits, foundation grants, government or agency benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignees.

I further agree that this agreement acts as an assignment of my rights and benefits to the extent this office rendered services; therefore if my insurance company and/or attorney obligated to make payment to me for the charges incurred at this office refuse to make such payment, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name. This office is also authorized to settle or otherwise resolve said claim or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby agree to give a full lien to said office against any and all insurance benefits named herein, or any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injuries or illness for which I have been treated by said office and assignees. I further agree that the assignee's right for payment shall not be bound by a statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and myself are resolved. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctors and/or this office's rights to recover and, and I agree to be held fully responsible for all debts I incur in this office.

It is further agreed that I shall remain personally responsible for the total amount due this office and assignee for its services. I further understand and agree that this Assignment, Authorization, and Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment from me immediately and at any time upon rendering service at their option. Such option requires that I pay for all sums due and owing in full within ten (10) days of demand. I further understand that a monthly service charge is computed by a periodic rate of 1% per month which is an annual percentage rate of 12% applied to the previous balance after deducting current payments and that the service charge may change without notice. I understand that all money due this office will be paid in a timely manner with no amount of money due past 90 days from the date of service, regardless of attorney liens, representations of any attorney, pending settlement(s) or other matters unless approved in writing by this office in advance of the 90 day limit. I further agree and understand that, if the need arises, accounts delinquent may be placed for collection and that I am fully responsible for all court costs, filing fees, attorney costs, and all associated collection costs.

I further understand and agree that, as necessary, this office and its staff may submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that Westbrook Medical Center, PLLC is given full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee. I understand that this office, the doctors and the staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any doctor's treatment, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I do agree that I am fully obligated to pay for all charges for all services rendered to me.

Print Name_____

Signature _____ Date _____

Westbrook Medical Center

"Consent for Purposes of Treatment, Payment & Healthcare Operations"

(In this document, "I" and "my" refer to the patient, and "facility" refers to Westbrook Medical.)

I consent to the use or disclosure of my protected health information by Westbrook Medical Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Westbrook Medical Center. I understand that analysis, diagnosis or treatment of me by this facility may be conditioned upon my consent which is evidenced by my signature below. Diagnostic testing may be required so a thorough analysis can be completed.

I understand that payment is due at the time services are rendered unless other arrangements have been approved in advance by the staff. I understand that Westbrook Medical Center may accept insurance assignments when the insurance coverage is through a group with whom they participate. If applicable, my consent for an assignment of my benefits to Westbrook Medical Center is designated by my signature below. Deductibles and co-payments must be honored at the time services are rendered. A finance charge will be added to outstanding balances. I understand that Westbrook Medical Center accepts cash, Visa, and MasterCard.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Westbrook Medical Center is not required to agree to the restrictions that I may request. However, If Westbrook Medical Center agrees to a restriction that I request, the restriction is binding to the facility.

I have to right to revoke this consent, in writing, at any time, except to the extent that Westbrook Medical Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition.

_____ _____

Signature of Patient or Representative | Print Name of Patient or Representative

_____ _____

Date of Signing | Description of Representative's Authority

CONSENT FOR PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

Westbrook Medical Center health care workers handle blood and other body fluids for many reasons such as when performing lab tests and cleaning equipment. It is the policy of Westbrook Health Center to test a patient for Hepatitis B, Hepatitis C and HIV (the virus that causes AIDS) if any employee or health care worker is exposed to a patient's blood or other body fluid in such a way that transmission of these infections could occur. Should an accidental exposure occur, the tests would be conducted at no cost to you. We are requesting that you consent to these tests prior to treatment. My signature below indicates my consent to test my blood or body fluid for Hepatitis B. Hepatitis C, or HIV.

_____ _____

Signature of Patient or Representative | Date

I decline to authorize the above testing:

_____ _____

Signature of Patient or Representative | Date

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600
865/769-2616 FAX

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Westbrook Medical Center located at the address above to receive my medical history information or treatment records from any source needed to enhance my care with their facility.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by providers at this facility unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the facility specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Unless otherwise specified, please release ALL records related to my care.

_____ Printed name of Patient

_____ Patient Date of Birth

_____ Patient Social Security Number

_____ Patient Signature

_____ Patient Signature Date

If you have received this form in error, please notify the above office immediately.

Please fax records as soon as possible unless noted otherwise.

Note: Faxed to _____ *at fax #* _____
FACILITY/PROVIDER *NUMBER*