REDINGTON FAIRVIEW GENERAL HOSPITAL
Skowhegan, Maine 04976

Long Acting Naltrexone Injection for Substance Use Disorder

Vivitrol (naltrexone) long acting intramuscular injection – 380 mgs **IM** every 28 days x _____ months
(if fewer than 12 months. Re-order required every 12 months minimum.)

Indication: Patient should be stable on oral naltrexone for at least 7 days prior to first dose of injection.

- ❑ Alcohol use disorder
- ❑ Opioid use disorder. Pregnancy testing required prior to initiation in patients of gestational potential.

  Negative pregnancy test_____

Not recommended for patients:

- currently taking opioids (If opiate use anticipated – e.g. elective surgery, discontinue injectable naltrexone 30 days prior)
- with acute hepatitis
- elevated liver enzymes 3 or more time normal
- in liver failure

Administration:

- If used for opiate use disorder, assess patient for signs of opiate withdrawal prior to administration. (See COWS) Allow drug to come to room temperature for at least 45 minutes prior to use. (stable x 7 days at RT)
- Complete naltrexone injection checklist
- Administer IM into the gluteal muscle, using one of the needles provided in the kit.
- Document exact location and alternate sides with each dose.

Ongoing monitoring: Periodic lab assessments may be collected during clinic for patient convenience. Doses will not be held pending results.

- ❑ Hepatic function panel every _____. (Labeling recommends "periodic.")
- ❑ Other:

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] Complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Name:_____

Duration of authorization:_____

Checklist for non-RFGH providers. Please:
[ ] Provider to provider communication is required. **Contact (207) 858-1500** to speak with the RFGH bridge clinic provider. Spoke with_____
[ ] Problem list & medication list attached to orders.

FAX completed to RFGH infusion CLINIC 207-858-2415

Provider_____ Date_____ time_____

Printed name_____ Phone # _____

RFGH Co-signature _____ Date_____ time_____
if above non-RFGH

Reviewed: 8/24
Copy: rfgh.net
Originator: Pharmacy

Patient name_____

Date of birth_____

Patient phone number_____