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INFORMED CONSENT
Extended Release Naltrexone Injection (Vivitrol)

I, _____ give permission to _____, &
Patient Name, relative or authorized agent for patient — Name of Provider

And any Registered Nurse or Licensed Practical Nurse which they may delegate to administer Vivitrol, which is an extended release (long acting) Naltrexone Injection. I understand this injection will be administered into the gluteal muscle.

I understand that:

- ✔ That I should return every 4 weeks for follow up with my treatment care team for Vivitrol treatment.
- ✔ Vivitrol is for the treatment of alcohol dependence and should not be actively drinking.
- ✔ Vivitrol is for the prevention of relapse to opioid dependence.
- ✔ Vivitrol may cause mild nausea which usually subsides in a few days. I may also experience tiredness, headache, vomiting, decreased appetite, and pain in joints and muscles.
- ✔ Vivitrol may cause dizziness and I should not drive or operate heavy machinery until I know how Vivitrol will affect me.
- ✔ A reaction at the site of injection may occur. Reactions include pain, tenderness, induration, swelling, redness, bruising, or itching.
- ✔ More serious site reactions could be necrosis (death of skin tissue) or serious skin infections. I should seek follow up medical attention with worsening skin reactions.
- ✔ I should be off all opioids for 7-10 and buprenorphine or methadone for 14 days before starting Vivitrol to avoid possibly serious opioid withdrawal that may require hospitalization.
- ✔ I should not be taking Vivitrol if I have any symptoms of opioid withdrawal.
- ✔ Vivitrol may cause depression and I will seek medical follow up if I experience symptoms of depression.
- ✔ Vivitrol may cause allergic pneumonia (lung infection) and I will seek medical follow up if I develop respiratory signs such as difficulty breathing, coughing, or wheezing.
- ✔ I will notify my provider if I become pregnant or am breastfeeding.
- ✔ I will notify my provider if I experience other unusual or significant side effects.

I CERTIFY THAT I HAVE READ & FULLY UNDERSTAND THIS CONSENT & THE MATTERS WHICH HAVE BEEN EXPLAINED TO ME.
I FURTHER CERTIFY THAT I HAVE FULL AUTHORITY & ACCEPT FULL RESPONSIBILITY TO SIGN THIS CONSENT FOR & ON BEHALF OF THE ABOVE-NAMED PATIENT.
I AM SIGNING FREELY & VOLUNTARILY. AN OFFER HAS BEEN MADE TO ANSWER MY QUESTIONS.

_____ _____ _____
SIGNATURE OF PATIENT, RELATIVE OR AUTH AGENT — DATE OF BIRTH — DATE OF SIGNATURE

_____ _____
SIGNATURE OF PROVIDER — DATE SIGNED