

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital (may not be faxed by patient).



SUBLOCADE (buprenorphine extended-release) Prescription/Pharmacy Intake Form

Pharmacy: _____ Pharmacy Fax: _____ Pharmacy Phone: _____ Date Needed: _____ Ship To: Prescriber's Office ONLY

PATIENT INFORMATION

Patient name: _____ DOB: _____ Male Female Address: _____ City: _____ State: _____ Zip code: _____ Phone # (Daytime): _____ Phone # (Evening): _____ E-mail Address: _____ Case Manager: _____ Insurance provider (Please include copy of front and back of card): _____ ID #: _____ Policy/Group #: _____ Phone #: _____ Patient is eligible for Medicare Name of Insured: _____ Employer: _____ Relationship to Patient: Self Other Prescription Card: Yes No Carrier: _____ Policy/Group #: _____ Will there be access to anaphylactic medications and oxygen at the administration site? _____

COPAY ASSISTANCE - Physician must register patient and initiate copay assistance.

Copay assistance ID #: _____

CLINICAL ASSESSMENT - Please complete ALL sections to avoid delays in filling prescription.

Patient is new to therapy Patient is restarting therapy Patient is currently on therapy Start date: _____ Primary Diagnosis Code and Condition (ICD-10): _____ Date of Diagnosis: _____ Other Diagnosis/Conditions: _____ Current Weight: _____ lb kg Date: _____ Current Height: _____ in cm Date: _____ Current med profile: _____ Allergies: _____

NEW PRESCRIPTION REQUIRED FOR SUBLOCADE

Table with 5 columns: Medication, Strength/Form, Directions/Frequency, Quantity, Refills. Contains 4 rows for medication entry.

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____ Address: _____ City: _____ State: _____ Zip code: _____ Office contact: _____ Phone: _____ Fax: _____ Email: _____ Best time to call: _____ Preferred method of contact: Email Phone Fax DEA #: _____ Data 2000 waiver DEA #: _____ State license #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written Substitution permitted Date

*** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA ***

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.