

# Sublocade® (buprenorphine extended-release) injection CIII

Four simple steps to submit your referral.

## 1 PATIENT INFORMATION

New patient  Current

Patient's name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
 Street address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Parent/guardian (if applicable) \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
 Evening phone \_\_\_\_\_ E-mail address \_\_\_\_\_  
 Patient's primary language:  English  Other If other, please specify \_\_\_\_\_

Please attach front and back of patient's insurance cards or complete information below.

Insurance company \_\_\_\_\_ Phone \_\_\_\_\_  
 Insured's name \_\_\_\_\_  
 Insured's employer \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
 Prescription card:  Yes  No If yes, carrier \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Is patient eligible for Medicare?  Yes  No  
 Does patient have a secondary insurance?  Yes  No

## 2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_  
 Prescriber's name and title \_\_\_\_\_  
 If NP or PA, under direction of Dr. \_\_\_\_\_  
 Office contact \_\_\_\_\_  
 Clinic/hospital affiliation \_\_\_\_\_  
 Street address \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 NPI # \_\_\_\_\_ License # \_\_\_\_\_  
 Deliver product to:  Office  Clinic  
 Clinic location \_\_\_\_\_

## 3 CLINICAL INFORMATION

Primary ICD-10 code: \_\_\_\_\_  
 NKDA  Known drug allergies \_\_\_\_\_  
 Concurrent meds \_\_\_\_\_

## 4 PRESCRIBING INFORMATION

	Medication	Strength / Formulation	Directions	Quantity/Refills
Loading Dose				Quantity _____ Refills _____
Maintenance Dose				Quantity _____ Refills _____

- Prescription use of this product is limited by the Drug Addiction Treatment Act (DATA) to prescribers who are authorized to treat opioid dependence and are DATA 2000-waivered.
- Sublocade® may only be delivered to a healthcare setting, and is NEVER dispensed to a patient directly.
- Sublocade can only be obtained through REMS-certified pharmacies; please visit [www.SublocadeREMS.com](http://www.SublocadeREMS.com) for more information.
- All prescriptions for Sublocade should be sent directly to the REMS-authorized dispensing pharmacy. For patient support and program information, please visit the manufacturer's product support website [www.Sublocade.com](http://www.Sublocade.com).

XDEA number required \_\_\_\_\_

By signing below, I certify that the above therapy is medically necessary and my office will accept shipment on behalf of patient for administration in office.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date \_\_\_\_\_ Substitution allowed \_\_\_\_\_ Date \_\_\_\_\_ Dispense as written \_\_\_\_\_

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.

Please fax completed form to your drug therapy team at 888.302.1028.

To reach your team, call toll-free 844.457.9195.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. 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 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.

All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners.

© 2018 Accredo Health Group, Inc. An Express Scripts Company. All Rights Reserved.

AHG-00522-021218 amc9402 CRP1802\_A0066