SUBSTANCE USE DISORDER
REFERRAL FORM (S.T. Genesis)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

INSURANCE INFORMATION

Insurance Provider	Insured's Name	Relationship to Patient	
Plan ID #	BIN#	PCN#	RX Group#
Eligible for Medicare ☐ Yes ☐ No If yes, list Medicare #	Prescription Card ☐ Yes ☐ No If yes, list carrier		

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Other/Concomitant Medications (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Treatment Center (please list)		
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
ICD-10 Codes ☐ F11.23 Opioid dependence with withdrawal ☐ Other Code _____ Description _____ ☐ Date of Diagnosis _____		
Procedure Code(s) ☐ _____ ☐ _____		

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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 to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DIRECTIONS	QTY	REFILLS
☐ S.T. Genesis	Place as directed by clinician for reduction of opioid withdrawal symptoms for up to 120 hours.		

_____ _____ _____ _____

Prescriber Signature | Date | Supervising Physician Signature (where required by state law) | Date

_____ _____ _____

DAW (Dispense as Written) | Date | Brand Necessary (must handwrite)

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV1121

SUBSTANCE USE DISORDER
REFERRAL FORM (Vivitrol)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

INSURANCE INFORMATION

Insurance Provider		Insured's Name	Relationship to Patient
Plan ID #	BIN#	PCN#	RX Group#
Eligible for Medicare ☐ Yes ☐ No If yes, list Medicare #		Prescription Card ☐ Yes ☐ No If yes, list carrier	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment		Date of Last Dose
Other/Concomitant Medications (please list)		
If the diagnosis is alcohol or drug dependence, will the patient abstain from using alcohol or drugs? ☐ Yes ☐ No		
Will treatment be part of a comprehensive management program that includes psychosocial support? ☐ Yes ☐ No		
Please provide detailed information of pharmacologic and non-pharmacologic therapies used:		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Treatment Center (please list)		
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
ICD-10 Codes ☐ F11.23 Opioid dependence with withdrawal ☐ Other Code _____ Description _____ ☐ Date of Diagnosis _____		

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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 to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Vivitrol (Naltrexone)	380mg single use carton	☐ Inject 380mg IM every 28 days ☐ Inject 380mg IM every _____ days		

I hereby authorize Amber Specialty Pharmacy to contact my prescribing provider to coordinate the delivery, receipt and storage of my Vivitrol prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

_____ Prescriber Signature

_____ Date

_____ Supervising Physician Signature (where required by state law)

_____ Date

_____ DAW (Dispense as Written)

_____ Date

_____ Brand Necessary (must handwrite)

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REV1121

SUBSTANCE USE DISORDER
REFERRAL FORM (SUBLOCADE)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City		State	ZIP
Email	Home Phone		Work Phone		Cell Phone
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)		Alt Contact Email			Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email		Office Phone	Office Fax	
Practice / Facility Name		Prescriber Name / Specialty		
Address		City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

INSURANCE INFORMATION

Insurance Provider		Insured's Name	Relationship to Patient
Plan ID #	BIN#	PCN#	RX Group#
Eligible for Medicare ☐ Yes ☐ No If yes, list Medicare #		Prescription Card ☐ Yes ☐ No If yes, list carrier	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Has patient been treated previously for this condition? ☐ No ☐ Yes: _____		
Is patient currently on therapy? ☐ No ☐ Yes: _____		
Other/Concomitant Medications (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Treatment Center (please list)		
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
ICD-10 Codes ☐ F11.20 Opioid Dependence, uncomplicated ☐ F11.21 Opioid Dependence, in remission ☐ Other Code _____ Description _____ ☐ Date of Diagnosis _____		

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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 to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

- The recommended dose of SUBLOCADE is 300 mg SQ initially at Months 1 & 2, followed by 100 mg monthly maintenance doses.
- Increasing the maintenance dose to 300 mg monthly may be considered for patients in which the benefits outweigh the risks.
- Examine the injection site for signs of infection or evidence of tampering or attempts to remove the depot.

DEVICE	STRENGTH/FORMULATION	DIRECTIONS	QTY	REFILLS
☐ SUBLOCADE Starter Dose ☐ SUBLOCADE Starter Dose not needed				
☐ SUBLOCADE Maintenance Dose				

*For abdominal subcutaneous injection only. Do not administer intravenously or intramusularaly.

- 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
- Serious harm or death could result if administered intravenously. SUBLOCADE forms a solid mass upon contact with body fluids and may cause occlusion, local tissue damage and thrombo-embolic events, including life-threatening pulmonary emboli, if administered intravenously
- Because of the risk of serious harm or death that could result from intravenous self-administration, SUBLOCADE is only available through a restricted program called the SUBLOCADE REMS Program. Healthcare settings and pharmacies that order and dispense SUBLOCADE must be certified in this program and comply with the REMS requirements.

_____	_____	_____	_____
Prescriber Signature	Date	Supervising Physician Signature (where required by state law)	Date
_____	_____	_____	
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)	

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REV1121