SUBSTANCE USE DISORDER REFERRAL FORM (SUBLOCADE)



PHONE 888.370.1724 | FAX 877.645.7514

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	н	ome Phone			Work Pho	one			Cell Phone					
Primary Contact Method (check one)	Cell Phone	Home Phon	e 🗆 Work Phone	e 🗆 Tex	xt 🗆 Email	🗆 Pri	mary Caregiver	DO NOT						
Primary Caregiver/Alt Contact Name (I	ct Email				Alt Contac	Contact Phone								
PRESCRIBER INFORMATION														
Name of Contact Sending Referral			Title		Preferred Contact Method (check one)									
Referral Contact Email					Office Phone			Off	ice Fax					
Practice / Facility Name	÷				Prescriber Na	me / S	Specialty							
Address				C	ity				State	State ZIP				
Prescriber State License #	DEA #	ŧ		N	PI #			Medi	caid UPIN #					
INSURANCE INFORMATION														
Insurance Provider				In	sured's Name			ationship to Patient						
Plan ID #	P	CN#			roup#									
Eligible for Medicare 🗆 Yes 🗆 No If y	yes, list Medica	re #		Pi	Prescription Card Yes No If yes, list carrier									
	* Ple	ase include	a copy of the	e fron	t and back	c of i	insurance ca	nrd *						
CLINICAL INFORMATION - Ple	ease includ	e applicable	clinical chart n	otes										
Has patient been treated previously for	this condition	? 🗆 No 🗆 Yes:												
Is patient currently on therapy?	□ Yes:													
Other/Concomitant Medications (pleas	e list)													
Ship to Address 🛛 Home 🛛 Prescri	ber's Office	Treatment Cen	ter (please list)											
Patient Height (cm/in)			Patient Weig	ht (kg/ll	bs)			Date Obtained						
ICD-10 Codes						_ 🗆 [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	STRENGT	H/FORMULATION		RECTIO	NS					QTY	REFILLS			

DEVICE	STRENGTH/FORMULATION	DIRECTIONS	QIY	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)

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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.

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SUBSTANCE USE DISORDER REFERRAL FORM (Vivitrol)



PHONE 888.370.1724 | FAX 877.645.7514

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

PATIENT INFORM	ATION														
Last Name		First Name		DOB Gender			□F	F Last 4 SSN			Primary Languag			ge	
Address				City					State	ZIP		ZIP			
Email	Email Home Phone					Work Phone Ce						ell Phone			
Primary Contact Metho	od (check one)	Cell Phone	Home Phon	e 🛛 Work Phone	🗆 Tex	xt 🗆 Email	🗆 Pri	imary Caregiver		от сс	NTACT				
Primary Caregiver/Alt Contact Name (If applicable) Alt Contact E										Al	t Contact	Phone			
PRESCRIBER INF	ORMATION														
Name of Contact Sending Referral Title						Preferred Contact Method (check one) 🗌 Email 🗌 Phone 🗌 Fax									
Referral Contact Email						Office Phone Office Fax									
Practice / Facility Nam	e					Prescriber N	ame / s	Specialty							
Address					Ci	ity		State Z							
Prescriber State Licens	ie #	DEA #	ŧ		N	PI #			м	ledicaid	aid UPIN #				
INSURANCE INFO	ORMATION														
Insurance Provider					In	sured's Name		Relationship to Patient							
Plan ID #	Plan ID # BIN#						PCN# RX Group#								
Eligible for Medicare	□Yes □No Ify	es, list Medica	re #		Pr	Prescription Card Yes No If yes, list carrier									
		* Plea	ase include	a copy of the	fron	t and bac	k of l	insurance ca	ard *						
CLINICAL INFORM	MATION - Ple	ease includ	e applicable	clinical chart no	otes										
Prescription Type	laïve/New Start	□ Therapy R	estart 🛛 Existir	ng Treatment			1	Date of Last Dose							
Other/Concomitant Me	dications (please	e list)													
If the diagnosis is alcol	nol or drug depe	ndence, will th	e patient abstain	from using alcohol	or drug	js? □Yes □N	10								
Will treatment be part	of a comprehens	ive manageme	ent program that	includes psychosoc	ial supp	oort? 🗆 Yes 🛛	No								
Please provide detailed	d information of	pharmacologic	and non-pharma	acologic therapies u	sed:										
Ship to Address 🛛 Ho	ome 🛛 Prescrit	ber's Office	Treatment Cen	ter (please list)											
Patient Height (cm/in)				Patient Weigh	t (kg/ll	kg/lbs) Date Obtained									
ICD-10 Codes F11.23 Opioid dependence with withdrawal Other Code Description Description															
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	DI	RECTIONS									QTY		REFILLS	
□ Vivitrol (Naltrexone)	380mg single u		Inject 380mg IM Inject 380mg IM												

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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REV.1121

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



PHONE 888.370.1724 | FAX 877.645.7514

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

PATIENT INFORM																
Last Name		First Name	Name DOB			Gender 🗆 M 🗆 F 🛛 Last 4 SSN			Pri		Primary Language					
Address					City					State		ZIP				
Email		Home Phone				Work Phone					Cell Phone					
Primary Contact Metho	d (check one)	Cell Phone	Home Phon	e □Te	Text 🛛 Email 🖓 Primary Caregiver 🖓 DO					D NOT CONTACT						
Primary Caregiver/Alt Contact Name (If applicable) Alt Contact						ail Alt Contac						lt Contact I	Phone			
PRESCRIBER INF	ORMATION															
Name of Contact Send	ing Referral			Title		Preferred Contact Method (check one)						il 🗆 Pho	ne 🛛] Fax		
Referral Contact Email						Office Phone Office Fax										
Practice / Facility Name						Pre	escriber Na	me / S	Specialty							
Address	Address				0	City						State		ZIP		
Prescriber State Licens	r State License # DEA #				1	NPI #				Me	dicai	icaid UPIN #				
INSURANCE INFORMATION																
Insurance Provider				1	Insured's Name					Relationship to Patient						
Plan ID # BIN#					F	PCN# RX Gro						oup#				
Eligible for Medicare 🗆 Yes 🗆 No If yes, list Medicare # Prescription Card 🗆 Yes 🗆 No If yes, list carrier																
		* Plea	ase include	a copy of the	e froi	nt ai	nd back	c of i	insurance ca	rd *						
CLINICAL INFORM	MATION - Ple	ease include	e applicable	clinical chart r	notes											
Other/Concomitant Me	dications (pleas	e list)														
Ship to Address 🛛 Ho	me 🗆 Prescri	ber's Office	Treatment Cen	ter (please list)												
Patient Height (cm/in)				Patient Weig	ht (kg/	(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														REFILLS	
🗆 S.T. Genesis	Place as directed by clinician for reduction of opioid withdrawal symptoms for up to 120 hours.															

Prescriber Signature

DAW (Dispense as Written)

Date

Date

Brand Necessary (must handwrite)

Supervising Physician Signature (where required by state law)

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.

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REV.1121

Date