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

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| 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)

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REV.1121

Date