

SUBSTANCE USE DISORDER REFERRAL FORM (SUBLOCADE)

PHONE 888.370.1724 | FAX 877.645.7514



AMBERTM
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 <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> 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) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone	Office Fax		
Practice / Facility Name		Prescriber Name / Specialty			
Address		City	State	ZIP	
Prescriber State License #	NPI #	Medicaid UPIN #	DEA # (required)		
DATA 2000 / X-DEA # (required)	Is Practitioner a certified Buprenorphine Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Certified:	Number of Patients:	
SUBLOCADE to be administered by (check one) <input type="checkbox"/> Prescribing Practitioner <input type="checkbox"/> Alternate Injector Practitioner					
Expected Location of SUBLOCADE administration (check one) <input type="checkbox"/> DEA-registered location of the PRESCRIBING practitioner for administration <input type="checkbox"/> DEA-registered location of ANOTHER administering practitioner (Alternate Injector) for administration					
Alternate Injector First/Last Name (if applicable)		Alternate Injector Office Phone			
Alternate Injector Address		City	State	ZIP	
Alternate Injector NPI #		Alternate Injector DEA #			

INSURANCE INFORMATION

Insurance Provider	Insured's Name	Relationship to Patient	
Plan ID #	BIN#	PCN#	RX Group#
Eligible for Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list Medicare #		Prescription Card <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	Is patient currently on therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____		
Other/Concomitant Medications (please list)	Patient Height (cm/in):	Patient Weight (kg/lbs):	Date Obtained:
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Treatment Center (please list)			
ICD-10 Codes <input type="checkbox"/> F11.20 Opioid Dependence, uncomplicated <input type="checkbox"/> F11.21 Opioid Dependence, in remission <input type="checkbox"/> Other Code _____ Description _____ <input type="checkbox"/> 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
<input type="checkbox"/> SUBLOCADE Starter Dose <input type="checkbox"/> SUBLOCADE Starter Dose not needed				
<input type="checkbox"/> SUBLOCADE Maintenance Dose				

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

- 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 waived.
- 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.

SUBSTANCE USE DISORDER REFERRAL FORM (Vivitrol)

PHONE 888.370.1724 | FAX 877.645.7514



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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) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list Medicare #		Prescription Card <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Naïve/New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will treatment be part of a comprehensive management program that includes psychosocial support? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please provide detailed information of pharmacologic and non-pharmacologic therapies used:	
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Treatment Center (please list)	
Patient Height (cm/in)	Patient Weight (kg/lbs)
Date Obtained	
ICD-10 Codes <input type="checkbox"/> F11.23 Opioid dependence with withdrawal <input type="checkbox"/> Other Code _____ Description _____ <input type="checkbox"/> Date of Diagnosis _____	

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> Vivitrol (Naltrexone)	380mg single use carton	<input type="checkbox"/> Inject 380mg IM every 28 days <input type="checkbox"/> 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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SUBSTANCE USE DISORDER REFERRAL FORM (S.T. Genesis)

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Referral Contact Email	Office Phone		Office Fax		
Practice / Facility Name	Prescriber Name / Specialty				
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INSURANCE INFORMATION

Insurance Provider	Insured's Name	Relationship to Patient	
Plan ID #	BIN#	PCN#	RX Group#
Eligible for Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list Medicare #		Prescription Card <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Treatment Center (please list)		
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
ICD-10 Codes <input type="checkbox"/> F11.23 Opioid dependence with withdrawal <input type="checkbox"/> Other Code _____ Description _____ <input type="checkbox"/> Date of Diagnosis _____		
Procedure Code(s) <input type="checkbox"/> _____ <input type="checkbox"/> _____		

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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MEDICATION	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> 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)

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