CHEMRX PHARMACY SERVICES, LLC
A PharMerica Company

**Prescription & Enrollment Form**

# Sublocade® (buprenorphine extended-release) injection CIII

**Four simple steps to submit your referral.**

## 1. PATIENT INFORMATION

❑ Newpatient ❑ Current

Patient's first name _____
Lastname _____ Middle initial _____
Dateof birth _____ ❑ Male ❑ Female SSN _____
Streetaddress _____ Apt# _____
City _____ State _____ Zip _____
Parent/guardian(ifapplicable) _____
Homephone _____ Work phone _____ Cellphone _____
Eveningphone _____ E-mail address _____
Patient'sprimarylanguage: ❑English ❑Other Ifother,pleasespecify _____

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

Insurancecompany _____ Phone _____
Insured's name _____
Insured's employer _____
Relationship to patient _____
Identification# _____ Policy/group# _____
Prescriptioncard: ❑Yes ❑No Ifyes,carrier _____
Policy# _____ Group# _____
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No
Copay Member ID # _____

## 2. PRESCRIBER INFORMATION

**All fields must be completed to expedite prescription fulfillment.**

Date _____ Time _____ Date medication needed _____
Prescriber'sfirst name _____ Last name _____
Prescriber's title _____
If NP or PA,underdirection of Dr. _____
Officecontactandtitle _____
Office contact e-mail _____
Office / clinic / institution name _____
Clinic / hospitalaffiliation _____
Streetaddress _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____
Deliver product to: ❑ Office ❑ Clinic
Clinic location _____

## 3. CLINICAL INFORMATION

**ICD-10 code required** _____

❑NKDA ❑Known drug allergies _____

Concurrent meds _____

## 4. PRESCRIBING INFORMATION

| | Medication | Strength/Formulation | Directions | Quantity/Refills |
|---|---|---|---|---|
| ❑ **Loading dose**<br>❑ **Maintenance dose** | | | | Quantity _____<br>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® will only be shipped to the prescriber's healthcare setting address as registered on their DEA registration.
- Sublocade can only be obtained through REMS-certified pharmacies; please visit **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**.

**XDEA number required** _____ **DEA number required** _____

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

_____
Patient Authorization/Signature

Further patient copay responsibility over $50 may result in an outreach to the patient to obtain authorization.

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. I also authorize ChemRx to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

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

PHYSICIANSIGNATUREREQUIRED

**Date** _____ **Prescriber Signature** _____

**Electronic Prescriptions submit to:**
**ChemRx Pharmacy Services, LLC., 790 Park Place, Long Beach, NY 11561**

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 844-331-4156.** To reach your team, call toll-free 800-506-8845.