

## SUBLOCADE PRESCRIPTION REFERRAL FORM

PATIENT INFO			PRESCRIBER INFO		
LastName, First Name	Sex: Male / Female		Today's Date	DEA #	
Date of Birth:	SSN:		Prescriber Name	NPI #:	
Home Phone Number	Other Phone Number		Address	City, State	Zip
Home Address	City, State	Zip	Phone Number	Fax Number	
Shipping Address: (DEA registered location)			Key contact (for Sublocade):		
			Phone #	Ext:	
			Email (optional)		

INSURANCE		
Rx ID #	Insurance company:	
RXGRP#	RXBIN#	RXPCN#
Copay card ID #		

**COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)**

CLINICAL INFORMATION
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Please provide any drug allergies (if applicable):

ATTACH PRESCRIPTION HERE
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<b>Rx</b>	DRUG:
	SIG:
REFILLS: _____ QTY TO DISPENSE: _____ XDEA # (Required)	
Prescriber Signature: _____ DATE: ____/____/____	

Sublocade should be administered subcutaneous injection only/ Sublocade can only be obtained through REMS certified pharmacy

**IMPORTANT NOTICE:** This fax is intended to be delivered only to the name addressee and contains confidential information may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately. If you have received this document by mistake, then destroy this document. Please direct all verification or notification to Banks Apothecary