Date Shipment Needed: ____________
MUST Ship To: DEA Registrant Address

Phone: 800.511.5144 • Fax: 855.423.4624

SUBLOCADE REFERRAL FORM

PATIENT INFORMATION				
Patient Name:	DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:		
Address:	City:	State:	Zip:	
Emergency Contact:	Phone:	**❑Please attach demographic information**		

PRESCRIBER INFORMATION				
Prescriber:		NPI:	State Lic:	
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:	

DEA REGISTRATION			
DEA:	XDEA:	Phone:	
Address:	City:	State:	Zip:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) ____________________

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): ____________________
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): ____________________
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):
  ____

INSURANCE INFORMATION

❑Please attach front and back of patient's insurance card (medical and prescription)

COPAY CARD ENROLLMENT	
❑Please check if enrolling in copay card	Copay ID:

PRESCRIPTION INFORMATION			
Drug Name			
❑Starter Dose **❑Starter Dose not needed**	Strength/Formulation:	Directions:	QTY: _____ Refills:_____
❑Maintenance Dose	Strength/Formulation:	Directions:	QTY: _____ Refills:_____
*For abdominal subcutaneous injection only. Do not administer intravenously or intramuscularly.			

Prescriber's Signature: ______________________________ ❑ DAW (Dispense as Written) **Date:** ____________

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should 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 AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.