Brixadi® (buprenorphine) extended-release injection for subcutaneous use (CIII)

Specialty Pharmacy Enrollment Form

Find participating specialty pharmacies at BRIXADIHCP.com/access-and-support or by scanning the QR code.

INSTRUCTIONS: Please complete and fax both pages to the chosen specialty pharmacy participating in Braeburn's limited distribution network.

1 Patient Information

First Name:	Last Name:		DOB: MM / DD / YYYY
Address:	City:	State:	ZIP Code:
Cell Phone:	Gender at Birth: ☐ Male ☐ Female	Email:	
Work/Home Phone:	Preferred Contact Method: ☐ Text ☐ Call ☐ Email		

2 Patient Insurance Information

Please fax a copy of both sides of the patient's insurance card(s).

Prescription Drug Insurer Plan:		Prescription Drug Insurer Phone:	
Member ID:	Rx Group #:	Rx BIN #:	Rx PCN #:
Primary Medical Insurance:		Insurance Phone:	
Policy ID #:	Group #:	Medicare Beneficiary ID #:	
Policyholder Name (First, Last):		Policyholder DOB:	Relationship to Patient:
Secondary Medical Insurance:		Insurance Phone:	
Policy ID #:		Group #:	
Policyholder Name (First, Last):		Relationship to Patient:	

3 Patient Enrollment in the BRIXADI Copay Savings Program (Optional: for commercially insured, eligible patients only)

☐ Patient is enrolled in the BRIXADI Copay Savings Program	Copay ID #:

4 Clinical Information (Ensure ICD-10 diagnosis code is provided)

Scheduled Injection Date (if known): MM / DD / YYYY

Primary Diagnosis (ICD-10 Code):

☐ Concomitant Medications:

☐ Allergies:

Because of the risk of serious harm or death that could result from intravenous self-administration, BRIXADI is only available through a restricted program called the BRIXADI Risk Evaluation and Mitigation Strategy (REMS).

NOTE: Prescriber must comply with his/her state-specific prescription requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form on page 2 should only be used if permitted by the applicable law in your state. The prescriber should include all required elements of a controlled substance prescription.

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Patient Name: _____ Patient DOB: _____

Patient Address: _____

5 Prescriber Information

Prescriber Name:		Prescriber NPI #:
State License #:	License State:	Prescriber DEA #:
Supervising Physician Name (if appropriate):		Supervising Physician DEA #:
Office Address:		City:
State:	ZIP Code:	Phone: / Fax:
Office Contact Name:	Contact Email Address:	Office Contact Phone:
Facility Name:	Practice NPI #:	Facility Type: ☐ Provider Office ☐ Outpatient Treatment Facility ☐ Other
DEA Shipping Address of Prescriber (if different from above):		
Shipping Location DEA # (if different from above):		

NOTE: BRIXADI orders cannot be fulfilled unless the shipping address matches the registered address on file with the DEA.

6 Prescription Information

Drug Name, Strength, and Dosage Form:

Directions/Sig:

Quantity (Numeric and Written):	**Refills (Numeric and Written):**

Primary Diagnosis (ICD-10 Code):

There are limitations to the logistics of supplying BRIXADI that could jeopardize continuity of care (eg, unanticipated shipment delays). We recommend prescribing sufficient BRIXADI supply to last 2 weeks if you deem it appropriate.

7 Prescriber Certification

I certify that the information provided in this Specialty Pharmacy Enrollment Form is complete and accurate to the best of my knowledge. I have prescribed BRIXADI based on my independent medical judgment that BRIXADI is medically necessary, and I will supervise the patient's medical treatment. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, and the Substance Use Disorder Patient Records Regulation (42 C.F.R. Part 2), as amended to provide the individually identifiable health information on this form to agents and service providers of Braeburn Inc. for benefits eligibility, coverage authorization, and coordination and dispensing of BRIXADI. I authorize the forwarding of this prescription and information to a dispensing specialty pharmacy.

When required by law, send electronic prescription or on official state prescription blank.

SIGN Prescriber Signature Required*

Date: MM / DD / YYYY _____

Dispense as written

Date: MM / DD / YYYY _____

Substitution allowed

*Signature stamps not acceptable.

Please see the BRIXADI Full Prescribing Information, including Boxed Warning, at brixadihcp.com or accompanying this document.

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braeburn