

Phone: 800.511.5144 • Fax: 855.423.4624

SUBLOCADE REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight:	<input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> 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) _____					
<input type="checkbox"/> Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____					
<input type="checkbox"/> Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____					
<input type="checkbox"/> Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____					
INSURANCE INFORMATION					
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)					
COPAY CARD ENROLLMENT					
<input type="checkbox"/> Please check if enrolling in copay card				Copay ID:	
PRESCRIPTION INFORMATION					
Drug Name					
<input type="checkbox"/> Starter Dose <input type="checkbox"/> Starter Dose not needed		Strength/Formulation:	Directions:	QTY: _____ Refills: _____	
<input type="checkbox"/> 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.

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