AcariaHealth
Specialty Pharmacy

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.