Phone: 267-921-0921
Fax: 215-357-2129
help@banksapothecary.com
3800 Horizon Blvd., Suite 103, Trevose, PA 19053

SUBLOCADE PRESCRIPTION REFERRAL FORM

PATIENT INFO			PRESCRIBER INFO		
Last Name, 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

Please provide any drug allergies:

Diagnosis code:

ATTACH PRESCRIPTION HERE

Rx

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