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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		

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