Treatment Referral Form for Medication Administration

This form may be used by prescribing healthcare professionals (HCPs) to refer patients seeking administration of SUBLOCADE® (buprenorphine extended-release) at an Additional Site of Care (ASOC).

Referring HCP should send completed referral form to the ASOC fulfillment site by fax.

Referring HCP Information

HCP Name:_____ NPI#:_____ DEA#:_____
Site Name:_____
Address:_____ City:_____ State:_____ ZIP Code:_____
Phone:_____ Fax#:_____
Office Contact:_____

ASOC Information

(Medication to be shipped to this location for administration)

ASOC Name:_____
NPI#:_____ DEA#:_____
Address:_____ City:_____ State:_____ ZIP Code:_____
Phone:_____ Fax#:_____

Patient Information

Fill out entirely OR ☐ attach Face/Demographic Information Sheet

Patient Name:_____ Date of Birth:_____ M☐ F☐
Address:_____ City:_____ State:_____ ZIP Code:_____
INSUPPORT Copay Assistance Program for SUBLOCADE ID:_____ Cell Phone:_____ Email:_____

Insurance Information

Fill out entirely OR ☐ fax a copy of insurance card (front AND back)

☐ Check here if the patient does not currently have insurance.
☐ Check here if attaching a copy of the patient's insurance card(s). Please attach a copy of both sides of all applicable patient medical and prescription drug insurance cards.

Please complete the required information below ONLY if not attaching a copy of the patient's insurance card(s) to this form.

☐ Private/Commercial ☐ Medicaid – State:_____ ☐ Medicare ☐ Other Primary Insurance Name:_____
Beneficiary/Cardholder Name:_____ Relationship to Patient:_____
Policy ID#:_____ Group#:_____ Primary Insurance Phone Number:_____

If patient has a separate prescription coverage plan, please add below (for Medicare patients, please use their Medicare Part D information).

Pharmacy Benefit Plan Name (if applicable):_____ Policyholder Name:_____ Relationship to Patient:_____
Policy ID#:_____ Rx Group#:_____ Rx BIN:_____ Rx PCN:_____ Pharmacy Benefit Plan Phone Number:_____

Patient Medical Information

☐ Primary Diagnosis Code:_____
Type(s) of Labs Completed (if any):_____ Date:_____
Treatment History:_____ ☐ New to Therapy ☐ Continuation of Therapy
Date of Last Administration:_____ Anticipated Injection Due Date:_____
Please list any previous treatments for opioid use disorder (OUD), including medications and dates:_____

Prescription Information

☐ **The prescription has been sent for fulfillment to:**_____ **(Specialty pharmacy name, if applicable)**

Dispense (check 1 dose only)	Directions	Days' Supply	Refills
☐ SUBLOCADE injection: 100 mg		☐ 7-day supply (for first dose only)	
☐ SUBLOCADE injection: 300 mg		☐ 26-day supply	

Prescriber Signature PLEASE SIGN AND DATE ONLY ONE LINE BELOW
Dispense as Written:_____ Date:_____ OR Product Substitution Permitted:_____ Date:_____

FOR COMPLETION BY ASOC ONLY

Fax this form back to the prescribing HCP with patient injection information completed below.

SUBLOCADE Treatment Status at Our Facility

Did the patient receive a SUBLOCADE injection? If yes, provide the date. ☐ Yes ☐ No Date:_____
Anatomical Location of Injection:_____ Lot#:_____ Expiry Date:_____
Has the patient's appointment been scheduled for their next SUBLOCADE dose? If yes, provide the date. ☐ Yes ☐ No Date:_____
Administering HCP's Comments:_____

Please contact INSUPPORT (844-467-7778) or www.INSUPPORT.com for insurance verification or any questions regarding coding/billing, claims submission, and other payer requirements.