Treatment Referral Form

This form may be used by prescribing healthcare professionals (HCP) to refer patients seeking administration of SUBLOCADE® (buprenorphine extended-release) at additional sites of care.

Referring HCP should send completed referral form to Treatment Site by fax or email.

Referring HCP Information

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

Treatment Site Information

Site Name:________________ HCP Name:________________
DEA#:________________
Address:________________ City:________ State:____ ZIP Code:____
Phone:________________ Fax#:________
Office Contact:________________ Email Address:________________

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 (Medicare patients please use 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 with medications for Opioid use Disorder (MOUD), include medications and dates:________________

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Product Information

***Prescribed Dose** (check one only)

Dispense	Directions	Refill Amount
SUBLOCADE injection: 100 mg	Administer SUBLOCADE in the abdomen subcutaneously once a month	
SUBLOCADE injection: 300 mg		

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

***Prescriber Signature** PLEASE SIGN AND DATE ONLY ONE LINE BELOW

Dispense as Written:________ Date:________ -OR- Product Substitution Permitted:________ Date:________

ACTION FOR ADMINISTERING PRACTITIONER

Fax this form back to the prescribing healthcare professional with patient injection information completed below

SUBLOCADE Treatment Status at Our Facility:

Was the patient injected with SUBLOCADE? If yes, provide the date. Yes No Date:________
Injection Location:________________ 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:________________

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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.

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