

Phone: 855-312-9074 Fax: 844-249-0014

Opioid Antagonist Sublocade or Brixadi (buprenorphine extended-release) Injection CIII enrollment form

(please use black ink)

Patient inforn	nation			Prescriber informat	tion		
Please complete the f	ollowing or send patie	ent demographic shee	et	Prescriber's name:			
Patient name:				DEA:			
Address:				NPI:			
Address 2:				State license:			
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Home phone:		Alternate phone:		Address:			
DOB:		•					
SS#/Drivers license# or State issued ID (Where applicable per state law)			te law)	City, State, ZIP: Fax: Fax:			
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Prior authorization ref	· ·			• • • •			
			pleted to proces	ss prescription) (Attach	separate sheet if nee	eded)	
Diagnosis - Please inc	lude diagnosis name ı	with ICD-10 code					
F11.20 Opioid dep	endence, uncomplica	ted		Allergies/Comments:			
F11.21 Opioid depe	endence, in remission			Concomitant medications:			
Other: ICD-10: _	Descrip	otion:		Weight:kg / lbs	Height:	_cm/in BMI:_	
Inpatient Treatment F	acility Discharge	Date:					
Outpatient Treatment	Facility Discharg	e Date:					
Other:							
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