Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Sublocade® Prescription Referral Form

Send your Rx to: Avella of Deer Valley | 24416 N. 19th Ave. Phoenix, AZ 85085 | Ph.: 877-546-5779 Fax: 877-546-5780 | **avella.com** If you have questions or concerns, please contact us.

1: Patient Information

Patient Name: ____ **Birthdate:** ____ **Sex:** Male Female **Height:** ____ **Weight:** ____ lbs. kg.

Preferred Phone: ____ **Known Allergies:** ____

Address: ____ **City:** ____ **State:** ____ **Zip:** ____

Alternate Caregiver Name: ____ **Preferred Phone:** ____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

____ ____ **DEA#:** ____ **NPI#:** ____ **Tax ID#:** ____

Address: ____ **Phone:** ____ **Fax:** ____

City, State, Zip: ____ **Key Contact:** ____ **Phone:** ____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

ICD-10: ____ **Concurrent meds:** ____

4: Prescription Information

	Medication	Strength/Formulation	Directions	Qty.	Refills
Loading Dose					
Maintenance Dose					

XDEA # required: ____ **DATA 2000 Waiver # required:** ____

- Prescription use of this product is limited by the Drug Addiction Treatment Act (DATA) to prescribers who are authorized to treat opioid dependence and are DATA 2000-waivered.
- Sublocade® may only be delivered to a healthcare setting, and is NEVER dispensed to a patient directly.
- Sublocade can only be obtained through REMS-certified pharmacies; please visit www.SublocadeREMS.com for more information.
- All prescriptions for Sublocade should be sent directly to the REMS-authorized dispensing pharmacy. For patient support and program information, please visit the manufacturer's product support website sublocade.com.

5: Patient Insurance Information

Prescription Benefits Medical Benefits **Copay Card ID #** ____

Card Holder ID: ____ **Group ID:** ____

RX BIN: ____ **RX PCN:** ____ **Medical Benefits ID:** ____

Card Holder Relationship: ____ **Phone:** ____

6: Office Shipping Information

Name: ____ **Office Contact:** ____

Address: ____ **City:** ____ **State:** ____ **Zip:** ____

Phone: ____ **Fax:** ____ **Date Medication Needed:** ____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written | Date | Substitution Permissable | Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: ____