Optum

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

Opioid Antagonist

Sublocade or Brixadi (buprenorphine extended-release)

Injection CIII enrollment form

(please use black ink)

Specialty Pharmacy Enrollment Form Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona or Virginia**

Patient information

Please complete the following or send patient demographic sheet

Patient name: _____

Address: _____

Address 2: _____

City, State, ZIP: _____

Home phone: _____ Alternate phone: _____

DOB: _____ Gender: _____

SS#/Drivers license# or State issued ID (Where applicable per state law)

_____

Language preference: ☐ English ☐ Spanish ☐ Other: _____

Prescriber information

Prescriber's name: _____

DEA: _____

NPI: _____

State license: _____

Group/Hospital: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Contact person: _____ Phone: _____

Insurance information *(Fill out entirely or fax a copy of patient's insurance card including both sides)*

Prior authorization reference number: _____

Medical information (Section must be completed to process prescription) *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ F11.20 Opioid dependence, uncomplicated

☐ F11.21 Opioid dependence, in remission

☐ Other: ICD-10: _____ Description: _____

Allergies/Comments: _____

Concomitant medications: _____

Weight: _____ kg / lbs Height: _____ cm / in BMI: _____

Inpatient Treatment Facility ☐ Discharge Date: _____

Outpatient Treatment Facility ☐ Discharge Date: _____

Other: _____

Prescription information (Prescription is void if more than one (1) prescription is written per blank)

Select medication doses		Medication	Dose/Strength	Directions	Quantity	Days supply	Refills
☐	Loading dose						
☐	Maintenance dose						

- Brixadi™ Weekly, Brixadi™ Monthly, and Sublocade® may only be delivered to a healthcare setting and is NEVER dispensed to a patient directly.
- Brixadi™ and Sublocade® can only be obtained through REMS-certified pharmacies; please visit www.BrixadiREMS.com or www.SublocadeREMS.com for more information.
- All prescriptions for Brixadi™ or 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 brixadi.com or sublocade.com.
- Optum Rx is REMS-certified and REMS authorized dispensing pharmacy.

Provider shipping information

Office contact: _____ Phone: _____

Shipping address: _____ Date medication needed: _____

Faxed by: _____

This form is provided as a convenience to prescribers. The pharmacy acknowledges that this form may not meet requirements for a valid prescription in every state. Prescriber are obligated to comply with the state-specific prescription requirements in the state where the prescription is issued, including, but not limited to, e-prescribing, state-specific prescription forms, and fax language. The pharmacy will contact prescribers for clarification on any prescription that does not meet state-specific requirements in the state where it is issued.

I authorize Optum® Specialty Pharmacy to bill my insurance company for this prescription and refills of this prescription. I understand that I am financially responsible for any co-pay/co-insurance amounts or other amounts not covered by my insurance. I understand that either I or my authorized representative will need to contact Optum® Specialty Pharmacy if there are changes in my insurance or I no longer need this prescription. I authorize this prescription and all refills of this prescription to be shipped to my physicians office at the address below.

Physicians name: _____ Address 1: _____

Signature of patient or patient's authorized representative: _____ Address 2: _____

This prescription is valid only if transmitted by facsimile from the prescriber's office.

***Prescriber authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber's Signature: _____ Date: _____

Supervising Physician: _____ Date: _____

Electronically signed faxed prescriptions are not acceptable. A manual signature of the prescriber is required.