Sublocade Enrollment Form

Fax Referral To: 1-800-323-2445 | Phone: 1-866-823-5179 | Email Referral To: Customer.ServiceFax@CVSHealth.com

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Patient must complete highlighted area)

Patient Name: _____ Address: _____

City, State, ZIP Code: _____ DOB: _____ Last Four of SSN: _____ Gender: ☐ Male ☐ Female

Primary Phone: _____ Alternate Phone: _____ Email: _____

By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account and health care. Standard data rates apply. Message frequency varies.

Designated Patient Contact

By signing below, I authorize my Contact, listed below, to receive logistical and administrative information related to my treatment, including ability to make decisions on my behalf, for which I will remain liable, regarding delivery of Sublocade (buprenorphine extended-release injectable). CVS Specialty is not liable for any decision(s) made by the Contact or actions taken in reliance on such Contact decisions. Please list any authorized Contact as set forth above:

Contact Name: _____ Relationship: _____ Phone: _____

Patient's Signature: _____ Date: _____

Patient Authorization

I hereby authorize CVS Specialty to contact my prescribing provider, on my behalf, to coordinate the delivery, receipt and storage of my Sublocade prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. I understand that my signature below serves as the Patient Ship Authorization, which means the pharmacy will not outreach/contact me and/or my designated contact on this form, prior to shipping medication except in certain circumstances.** I further agree to pay to CVS Specialty any required copayment or coinsurance amount, up to a total amount of $50, without prior outreach to me or my designated contact.

Patient's Authorization: _____ Date: _____

***CVS Specialty may contact patient and/or patient's designee in the event the patient's copay/coinsurance responsibility is greater than $50. Enrollment above is not available to Medicare and Medicaid patients because government payors are excluded from this offering. Copayment, copay or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.*

2 PRESCRIBER INFORMATION

Prescriber's First Name: _____ Prescriber's Last Name: _____ NPI#: _____

State License#: _____ DEA#: _____ XDEA#: _____

Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Facility ☐ Correctional

Practice/Facility Name: _____ Practice NPI#: _____

Practice Address (Ship to Address): _____ City: _____

State/ZIP Code: _____ Phone Number: _____ Fax Number: _____

Office Contact Name: _____ Contact's Phone: _____

Note: The pharmacy will only ship to the address registered with the DEA, associated with the DEA# provided above.

3 INSURANCE INFORMATION (Please fax copy of prescription/medical insurance cards with this form, front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No

Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Telephone: _____

Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION (to be completed by prescriber only)

Has patient previously been treated for Opioid Use Disorder? ☐ Yes ☐ No

If YES, list all previous medications: _____

List concomitant medications (e.g., adjunctive depression medications, sedative hypnotics, psychostimulants): _____

_____

_____

Allergies: _____ Scheduled Injection Date: _____

Diagnosis (ICD-10):	
☐ F11.2 Opioid dependence	☐ F11.24 With opioid-induced mood disorder
☐ F11.20 Opioid dependence, uncomplicated	☐ F11.25 Opioid dependence with opioid-induced psychotic disorder
☐ F11.21 Opioid dependence, in remission	☐ F11.28 Opioid dependence with other opioid-induced disorder
☐ F11.22 Opioid dependence with intoxication	☐ F11.29 With unspecified opioid-induced disorder
☐ F11.23 Opioid dependence with withdrawal	☐ Other Code: _____ Description: _____

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5 PRESCRIPTION INFORMATION (to be completed by prescriber only)

Because of the risk of serious harm or death that could result from intravenous self-administration, **Sublocade is only available through a restricted program called the Sublocade Risk Evaluation and Mitigation Strategy (REMS) Program**. Health care settings and pharmacies that order and dispense Sublocade must be certified in this program and comply with the REMS requirements. Sublocade should only be prepared and administered by a licensed health care provider.

NOTE: *Prescriber must comply with his/her state-specific prescription requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form below should only be used if permitted by the applicable law in your state. The prescriber should include all required elements of a controlled substance prescription.*

Patient Name (First and Last): _____ Patient Date of Birth: _____

Patient Address: _____

Drug Name, strength, and dosage form: _____

Directions/Sig: _____

Quantity Authorized (Numeric): _____ (Written): _____

Prescriber Name: _____ Prescriber Phone Number:_____

Prescriber DEA #:_____ XDEA #: _____ State License #: _____

Prescriber Address: _____

Supervising Physician Name: _____ Supervising Physician Phone Number:_____

Supervising Physician Address: _____ Supervising Physician DEA#: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

May Substitute/ Product Selection Permitted / Substitution Permissible	Dispense As Written/ Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: _____ **Date: _____**	**Prescriber's Signature: _____** **Date: _____**
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

I have obtained written authorization from the Patient to disclose the Patient's personal health information and any other information on this enrollment form as may be required to comply with all applicable federal and state laws and regulations, including, but not limited to, the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164) and the Confidentiality of Substance Use Disorder Patient Records Regulation (42 C.F.R. Part 2), as amended from time to time.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.