Magellan Rx Pharmacy

Sublocade Order Form

Complete the following information and return to Magellan Rx Pharmacy, LLC.
Please attach all prescriptions on Official State Prescription form if mandated by individual state laws. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form or hard copy prescription.
E-Prescribers please note that we are a surescripts© network pharmacy.

Patient Information *Please type or print clearly*	Name		DOB	SSN
	Street Address			○ Male ○ Female
	City		State	Zip
	Home Phone	Work		Cell
	Emergency Contact	Phone		Relationship
Health Conditions	Treatment Diagnosis			ICD-10 Code
	Other Diagnosis / Health Conditions			
	Height	Weight	Allergies	
	Diabetic ○ Yes ○ No	If yes: ○ Non-insulin dependent ○ Insulin dependent		

Insurance Information	**Prescription Benefit**	**Medical Benefit**
	Insurance Company	Insurance Company
	Policy #	Policy #
	Policy Holder Name	Policy Holder Name
	Group #	Group #
	BIN # PCN #	
	Cust. Service phone #	Cust. Service phone #
	Copay Assist ID	
	○ I consent to allow Magellan Rx to auto-enroll me in any patient assistance program.	

Prescription Order *Prescription must be faxed from physician's office*	Prescribed Dose: ○ SUBLOCADE™ 300 mg ○ SUBLOCADE 100 mg		
	Scheduled Injection Date (if known)		
	SIG	Quantity	Refills

*** THIS FORM IS NOT VALID IN THE STATE OF ARIZONA ***

Prescriber Information

- *I certify that the above therapy is medically necessary and the information is accurate to the best of my knowledge.*
- *This request for services has been prepared exclusively by the provider or provider's office identified in this request ("my Practice").*
- *The prescribed medication is medically appropriate for the patient identified based on my best professional judgment and that my practice will be supervising the patient's treatment.*
- *My Practice has obtained written authorization from the patient identified in this request to disclose the patient's personal health information and any other information on this enrollment form as may be required by Magellan Rx Pharmacy to provide the services requested, as required to comply with all federal and state laws and regulations relating to medical and/or health privacy, including, but not limited to, the HIPAA Privacy Rule (codified at 45 C.F.R. Parts 160 and 164) and Confidentiality of Substance Use Disorder Patient Records Regulation (codified at 42 C.F.R. Part 2), asamended from time to time.*

Prescriber Signature			Date
Print Prescriber Name		Prescriber Type ○ MD ○ DO ○ PA ○ NP	
Prescriber NPI #	DEA #	X-DEA #	License #
Office Contact			
Street Address / Suite Number			
City		State	Zip
Office Phone		Office Fax	

WARNING: RISK OF SERIOUS HARM OR DEATH WITH INTRAVENOUS ADMINISTRATION; SUBLOCADE RISK EVALUATION AND MITIGATION STRATEGY

- **Serious harm or death could result if administered intravenously. SUBLOCADE forms a solid mass upon contact with body fluids and may cause occlusion, local tissue damage, and thrombo-embolic events, including life threatening pulmonary emtboli, if administered intravenously.**
- **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 REMS Program. Healthcare settings and pharmacies that order and dispense SUBLOCADE must be certified in this program and comply with the REMS requirements.**

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Patient Name | DOB

By signing below,

I authorize (i) my treatment provider including their staff and any affiliated group practices, (ii) the health insurer(s) listed on my enrollment form, and (iii) one or more network specialty pharmacies* to use and disclose to LiquidHub, Inc., and my authorized patient representative (if named) (collectively "Recipients"), and for those Recipients to share among themselves, my personal and medical information. This includes any information on this Magellan Rx Pharmacy SUBLOCADE Order Form and about my medical treatment with SUBLOCADE (taken together, "Information"), which can be shared as needed or for a specific purpose, including more of the following:

1. to conduct insurance benefit verification and communicate my health insurance company's requirements for access to treatment with SUBLOCADE;
2. to coordinate services and route information between Recipients to help in the coordination of my treatment with SUBLOCADE;
3. to provide me with educational information and materials related to my enrolled services;
4. to invite me to participate in optional surveys about my treatment, and/or;
5. to provide me with eligibility or program information about, and help with my enrollment and continued participation in programs or sources of funding to help me with the costs of my medication.

I understand that:

1. My default communication method to receive information from Magellan Rx Pharmacy is via US mail. At any time, I can change my communication method, or any other information on this form by calling **866-554-2673.**
2. Signing this form is my choice. If I do not sign this form, it will not affect my ability to obtain treatment, insurance, or insurance benefits.
3. This authorization does not permit the recipient of my mental health and drug treatment information to further share the information without my permission unless allowed under state or federal law. Any information shared as a result of this authorization must include a notice that such information cannot be shared further.
4. This authorization will expire two (2) years from the date I sign the form.
5. I can revoke my authorization at any time by calling **866-554-2673** or by mailing a signed written statement of my revocation to **6870 Shadowridge Drive Suite 111. Orlando FL, 32812.** I understand that after the date I revoke this authorization, there will be no further use or disclosure of my information, except to the extent that action has already been taken based on this authorization.
6. I understand I have the right to receive a copy of this authorization after I sign it.
7. Indivior Inc. is paying Magellan Rx Pharmacy for services and/or data relating to SUBLOCADE.

Authorized Representative (Optional)
I grant permission for Magellan Rx Pharmacy to contact the authorized representative listed below to discuss any information provided within this form, to discuss my treatment with SUBLOCADE, and communicate my ongoing preferences and need for services.

Authorized Representative/Guardian Name | Relationship to Patient | Phone Number

Patient Signature
By signing below, I confirm that I have read, understand and agree to the terms of this form and also certify that all information that I have provided in this application is complete and accurate.

Patient Signature | Date

Generic equivalents are usually less expensive than brand name drugs. If we dispense a brand name drug, you may be responsible for a higher copayment and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box. ☐ **I do not accept a generic equivalent.**

6870 Shadowridge Drive, Ste 111, Orlando, FL 32812 | Phone: 866-554-2673 | Fax: 866-364-2673

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