Orsini
Specialty Pharmacy Services

SUBLOCADE PATIENT ENROLLMENT FORM

1111 Nicholas Boulevard
Elk Grove Village, IL. 60007
Ph# 800-241-1534
Fax# 877-785-7737

STEP 1 Patient Contact Information

First Name ____ MI ____ Last Name ____ DOB (MM/DD/YYYY) ___/___/___ Gender ☐ M ☐ F

Address ____ City ____ State ____ ZIP ____

Primary Phone Number ( ) ____ Cell Phone Number ( ) ____ Email Address ____

STEP 2 Patient Insurance Information

(Please attach a copy of both sides of the patient's insurance card(s). If not available, please complete the information below.)

Patient is insured ☐ Y ☐ N

Primary Insurance Type ☐ Private/Commercial ☐ Medicaid ☐ Medicare ☐ Other

Secondary Insurance Type ☐ Private/Commercial ☐ Medicaid ☐ Medicare ☐ Other

Primary Insurance Name ____

Beneficiary/Cardholder Name ____ Relationship to Patient ( )

Policy ID # ____ Group # ____ Primary Insurance Phone Number ____

Secondary Insurance Name (if applicable) ____

Beneficiary/Cardholder Name ____ Relationship to Patient ( )

Policy ID # ____ Group # ____ Phone ____

If patient has a separate prescription coverage plan, please list below. (Medicare patients please use Medicare Part D information.)

Pharmacy Benefit Plan Name (if applicable) ____

Policyholder Name ____ Relationship to Patient ____

Policy ID # ____ Rx Group # ____

Rx BIN ____ Rx PCN ____

( ) ____

Pharmacy Benefit Plan Phone Number

Secondary Pharmacy Benefit Plan Name (if applicable) ____

Policyholder Name ____ Relationship to Patient ____

Policy ID # ____ Rx Group # ____

Rx BIN ____ Rx PCN ____

( ) ____

Pharmacy Benefit Plan Phone Number

STEP 3 Patient Copay Assistance

Copay Member ID (if obtained): ____

Patient Name: ____ Provider Name: ____ Case ID: ____

Fax: 877-785-7737

Sublocade™
(buprenorphine extended-release) injection for subcutaneous use ℄
100mg·300mg

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STEP 4 Provider Information

First Name | Last Name | Data 2000 Waiver ID#

NPI # | State License # | DEA #

Site of Administration (Name of Facility) | Site of Administration NPI # | Tax ID #

Site of Administration Address (Ship to Address) | City | State | Zip

Ph# ( ) | Fax# ( )

Site Contact First and Last Name | ( ) Site Contact Phone Number | Site Contact Email Address

STEP 5 Treatment Information (To be completed by the provider only)

ICD-10 Diagnosis Code: _____ Prescribed Dose: ☐ SUBLOCADE™ 100 mg ☐ SUBLOCADE™ 300 mg

Directions: Inject subcutaneously (SC) in abdomen every month. To be administered by healthcare provider only.

Scheduled Injection Date: _____(if known) Quantity: _____ Refills: _____

Allergies:_____ Current medications:

STEP 6 Authorized Representative (Optional)

I grant permission for Orsini Pharmaceutical Services, LLC to contact the Authorized Representative listed below to discuss any information provided within this enrollment or consent form, to discuss my treatment with SUBLOCADE, and communicate my ongoing preferences and need for copay assistance.

I understand that Orsini Pharmaceutical Services, LLC is not liable for any actions taken in response to direction provided by my Authorized Representative.

Authorized Representative/Guardian Name (please print) | Relationship to Patient | ( ) Phone Number

Patient Signature

By signing below, I confirm that I have read, understand and agree to the Authorized Representative Consent. By signing, I also certify that all information that I have provided in this application is complete and accurate.

X
Patient Signature | Date

STEP 7 Provider Signature

X Provider Signature | Date

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by the express authority of the sender to the named addressee.

Patient Name: _____ Provider Name: _____ Case ID: _____

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