giant eagle specialty pharmacy

Phone: 1-888-792-1552
Fax: 1-888-216-2510

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#0221)
20160 Center Ridge Road, Suite 201
Rocky River, OH 44116

SUBLOCADE® ENROLLMENT FORM

Today's Date: _____

Patient Information

Patient's First Name_____ Patient's Last Name: _____
DOB: _____ □ Male □ Female
Address: _____ City:_____ State:_____ Zip:_____
Phone #: _____ Alternate Phone #:_____
Height: _____ Weight: _____ Caregiver: _____Allergies: _____

Insurance Information

Primary Insurance: _____Phone:_____
Policy #: _____ Group#:_____
BIN #_____ PCN #: _____ Prior Authorization Ref #:_____

Diagnosis/Medical Information

□ F11.20 Opioid dependence, uncomplicated □ F11.21 Opioid dependence, in remission
□ Other ICD-10: _____ Description: _____
Concurrent Medication List (including OTC and supplements): _____
_____
Notes: _____

Prescription Information

MEDICATION	SIG	QTY	REFILLS
□ Sublocade® 300mg Loading Dose	Administer 1 injection subcutaneously into the abdomen once monthly. MUST BE ADMINISTERED BY HEALTHCARE PROVIDER, DO NOT DISPENSE DIRECTLY TO PATIENT.	1	0 or Please Specify Below _____

- Prescription use of this product is limited by the Drug Addiction Treatment Act (DATA) to prescribers authorized to treat opioid dependence and DATA 2000-waivered.
- Sublocade® prescriptions are shipped only to the prescriber's healthcare setting address as listed on their DEA registration and is never dispensed directly to patients.
- 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 www.Sublocade.com

This form is provided for informational and convenience purposes only. The completion of this form by a prescriber may not constitute a valid prescription in accordance with state law. The pharmacy may contact the prescriber upon receipt of this enrollment form in order to obtain a valid prescription under state law.

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____Contact Name: _____
XDEA#: _____
Phone #:_____ Fax #: _____NPI #:_____
Office/Shipping Address: (must match DEA registered address)
Office Address:_____ City:_____ State:_____ Zip:_____
State License #: _____ DEA #:_____
In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" in the space below.
_____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: _____ **Date**:_____