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

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