MATR$_X$VIP

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Questions? E-mail us at **INFO@MATRIX-PHARMACY.COM** or Call **(866) 410-3306**. We are here to assist you!

SUBLOCADE® 100MG ENROLLMENT FORM

PATIENT INFORMATION & DEMOGRAPHICS

ORDER DATE: ____________________ **APPOINTMENT DATE (if known):** ____________________

LAST NAME: ______________________________ **FIRST NAME:** ______________________________

ADDRESS: ____

CITY:______________________________ **STATE:** ____________ **ZIP:** ____________________

PHONE: ______________________________ **DOB:** ____________________ □ **Female** □ **Male**

INSURANCE COMPANY: ______________________________ **ID#:**____________________

GROUP#: ____________________ **EMERGENCY CONTACT:** ______________________________

PRESCRIPTION INFORMATION

DIAGNOSIS	ALLERGIES
□ **F11.20** (Opioid dependence, uncomplicated)	□ **NKA**
□ **F11.21** (Opioid dependence, in remission)	□ ______________________________
□ _______ ______________________________	

□ **SUBLOCADE® 100mg** Maintenance Dose **Quantity:** 1

Directions: Administer 1 injection subcutaneously in abdomen once monthly **Refills:** ____________

The Drug Addiction Treatment Act limits prescription use of this product to DATA 2000-waivered prescribers authorized to treat opioid dependence. Sublocade is only shipped to DEA-registered healthcare settings and never directly to patients. The completion of this form may not constitute a valid prescription in accordance with state law. The pharmacy will contact the prescriber to obtain a valid prescription in suchstates.

PRESCRIBER INFORMATION

OFFICE/CLINIC NAME: ______________________________ **ATTN:** ______________________________

OFFICE ADDRESS: ____

CITY:______________________________ **STATE:** __________ **ZIP:** ____________________

PHONE: ______________________________ **FAX:**______________________________

PRESCRIBER NAME ____

NPI: ____________________ **LICENSE:**____________________ **DEA:** ____________________

PRESCRIBER SIGNATURE:____ **DATE:** ____________

(substitution permissible if applicable)

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

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