Note: This prescription is valid only if transmitted by facsimile from the prescriber's office. This form is a referral form and is not a valid prescription in Arizona or Virginia. Physician attests that this is his/her legal signature (NO STAMPS). New York and Iowa providers must submit an electronic prescription. Prescriber must comply with his/her state-specific prescription requirements for controlled substances including state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element. For this reason, the prescription form below should only be used if permitted by the applicable laws in your state. The pharmacy will contact prescribers for clarification on any prescription that does not meet state-specific requirements in the state where it is issued.

Brixadi and Sublocade Prescription & Enrollment Form

Genoa Healthcare®

genoa healthcare®

Patient Information

Patient Name: _____ DOB: _____
Address: _____ Address 2: _____
City, State, Zip: _____
Home Phone: _____ Alternate Phone: _____
Gender: _____ Language Preference: _____
Order Date: _____ Appointment Date (if known): _____

Prescriber Information

Prescriber Name: _____
DEA: _____ NPI: _____
State License: _____ Group/Facility: _____
Address: _____ City/State/Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Contact Person Phone: _____

Insurance Information

Insurance Name: _____ Group: _____
ID: _____ PA Reference Number: _____

Medical Information

☐ F11.20 Opioid dependence, uncomplicated
☐ F11.21 Opioid dependence, in remission
☐ Other: ICD-10 + Description:
☐ Inpatient Treatment Facility
☐ Outpatient Treatment Facility
☐ Other _____

Allergies/Comments: _____
Concomitant Medications: _____
Weight, Height, BMI: _____
Discharge Date: _____
Discharge Date: _____

Prescription Information (prescription is void if more than one (1) prescription is written per blank)

Select Doses	Medication	Dose/Strength	Directions	Quantity	Days Supply	Refill
☐ Loading Dose						
☐ Maintenance Dose						

Shipping Information

Office contact: _____ Phone: _____
Shipping address: _____ Date medication needed: _____
Faxed by: _____ DAW (yes/no): _____

Prescriber Signature: _____ **Date:** _____