

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®



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:** _____

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Genoa Healthcare and/or one of its affiliates. This form is not a valid prescription in Arizona and Virginia.