AODA & SUD Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

1. Patient Information

Patient Name	Birthdate	Sex: ☐ Male ☐ Female
Address	City State	Zip:
Preferred Phone		

*****Insurance Information: Please fax a copy of the FRONT and BACK of ALL Insurance cards (Prescription and Medical)*****

2. Prescriber Information

Prescriber Name:	Prescriber NPI#:	Prescriber DEA#:
Address:	Phone:	
City: State: Zip:	Fax:	Contact:

3. Diagnosis/Clinical Information

☐ F10.20 Alcohol Dependence, Uncomplicated ☐ F11.20 Opioid Dependence, Uncomplicated

☐ F10.___ ☐ F11.__

Known Allergies Current Medications

******Please Fax clinical notes, labs, and tests with the prescription to expedite Prior Authorization process******

4. Prescription Information

Medication	Dose/Strength		Sig	QTY.	Refills
☐ Lucemyra®	0.18 mg tablet		Take 1-4 tablets by mouth four times a day with 5 – 6 hours in between doses as needed for withdrawal symptoms	☐ 96 ☐ 192	_____
☐ Vivitrol®e	380 mg		Inject 380 mg IM every 4 weeks	1 Kit	_____
☐ Naltrexone Tablets	50 mg tablet		Take 1 tablet by mouth daily X ____ Days	QS	_____
☐ Narcan Nasal Spray	4 mg (One Unit= 2 Sprays)		Administer a single spray into one nostril. Read package for additional doses	1 Kit	_____
☐ ZIMHI Prefilled Syringe	5 mg/0.5 ml		Administer per instructions for use	1 Kit	_____
☐					_____
☐ Sublocade	100 mg/0.5 ml		Inject subcutaneously every month. ***To be administered by a healthcare provider only.***	1 Kit	_____
☐ Sublocade	300 mg/1.5 ml	☐ Initial ☐ Maintenance	Inject subcutaneously every month. ***To be administered by a healthcare provider only.***	1 Kit	_____

Sublocade Additional Information

Sublocade to be administered by (check one)	☐ Prescribing Provider	☐ Alternate Injector Prescriber

Expected Location of Sublocade Administration

☐ DEA-registered Location of Prescribing Practitioner for administration	☐ DEA-registered location of ANOTHER administering practitioner (Alternate injector) for administration		
Alternate Injector Name	Alternate Injector Office Phone		
Alternate Injector Address	City	State	Zip
Alternate Injector NPI#	Alternate Injector DEA#		
Prescriber Signature	Date:		

I authorize Evergreen Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.