August 2023

Office-based addiction treatment: Sublocade access

New Jersey provider toolkit

Camden Coalition

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About this toolkit

This toolkit provides an overview of best practices for New Jersey providers looking to secure patient access to Sublocade — a long-lasting injectable treatment for opioid use disorder — by documenting suggested workflows and MCO- and pharmacy-specific processes. Sublocade is the only extended-release injectable buprenorphine product FDA approved for the treatment of opioid use disorder at the time of the publication of this document.

This toolkit is the culmination of the Camden Coalition's OBAT (office based addiction treatment) Sublocade pilot, which was a partnership with NJ Medicaid's Office of Behavioral Health, managed care organizations (MCOs), and clinical partners. The Sublocade pilot was a two-step project to explore opportunities for improved patient access to Sublocade. We first collaborated with Cooper's Center for Healing and the MCOs to map and analyze the current process of connecting members to Sublocade across affiliated and independent specialty pharmacies. We piloted and tracked process improvements, presented our findings with the NJ Medicaid's Office of Behavioral Health and the MCOs, worked to implement recommendations of these partners, and have now codified the results in this toolkit. Our goal is to reduce clinic staff time and ease patient burden by reducing the need for monthly patient verbal consent, and by clearly documenting the various MCO requirements and best practices for coordinating with specialty pharmacies.

This toolkit was prepared by the Camden Coalition with support from New Jersey Medicaid's Office of Behavioral Health following a pilot program to investigate and improve OBAT navigator billing issues between providers and MCO partners.

About the OBAT model

The OBAT model is designed to enhance access and improve utilization of MAT services for Medicaid beneficiaries by establishing additional supports and reducing administrative barriers to providing addiction services in ambulatory settings. Using a medication-first approach, the model makes it possible for patients to access medications without first engaging in behavioral health services. OBAT is open to all specialties, not just primary care.

The OBAT model requires that the office employ a navigator. Navigators can assist with addressing identified barriers and connecting patients with community social service, recovery supports and behavioral health resources on an as-needed basis. (Patients are not required to engage in navigation services, but they must be offered.) For more information about the OBAT model and how to bill for services, please review the *OBAT provider billing resource guide*.

Sublocade infrastructure requirements

The **Northern NJ Center of Excellence** and the **Southern NJ Center of Excellence** are available to provide support, guidance, and insight around Sublocade. A few things to note before you prescribe:

- *For clinical guidance on Sublocade, please review **SAMSA's Quick Start Guide***
- *The healthcare setting must be **Sublocade REMS** certified. Clinics do not need to be REMS certified to receive Sublocade for direct administration to a specific patient.*
- *The DEA address associated with the prescriber is the address where medicine will be delivered.*
- *Sublocade must be stored in a locked fridge within a locked room. **(More storage info here.)***

Accessing Sublocade: Process overview

This process flow describes the steps required for a patient to receive Sublocade. **The biggest barrier tends to be "consent for medication delivery" step**. Our pilot found it would take patients between 4-6 weeks to receive Sublocade, and many patients also had their prescription canceled due to the pharmacy being unable to gain verbal consent from the patient within the required 28 days. Our pilot supported the streamlining and reduction of required patient consent for medication delivery, which we outline in the following page.

Patient appointment

- Determine if the client may benefit from Sublocade and, if so, prescribe the medicine.

Prescription to pharmacy

- Send precription to a specialty pharmacy, dictated by insurance (more below)
- Most specialty pharmacies accept an electronic Rx; it can be useful to include clinical background information such as H&P.

Prescription clears MCO

- During this step the pharamcy will clear the script with the MCO, either as a medical or pharmacy benefit. They may reach out with questions if they have issues. (more below)

Consent for medication delivery

- Consent process for medication delivery to the clinic varies by pharmacy (more below.)
- Some specialty pharmacies do not require patient consent, while others require it once per duration of the prescription, and others require consent for each delivery each month.
- If consent is required, the prescription is canceled within 28 days if unable to obtain consent.

Medicine ships

- The pharmacy will contact you to schedule a delivery date during business hours.
- Please note: the address on the prescriber's DEA license is where the Sublocade will be delivered.

Medicine stored

- Your clinic must have a locked fridge to store the medicine inside a locked room. Ambulatory care facilities may have additional storage requirements. (See link above.)

Patient appointment

- Patient recieves the medicine at the clinic/DEA address of the prescriber.

Accessing Sublocade: An MCO breakdown

This table summarizes and identifies key differences in Sublocade provision, including information about patient consent, among the various managed care organizations. Please use this as a reference for helping your practice obtain Sublocade.

	Aetna	**Amerigroup**	**Horizon**	**United**	**Wellcare**
Affiliated specialty pharmacy	CVS Specialty Pharmacy	CVS Specialty Pharmacy	Accredo	Optum	Acaria
Is there a Sublocade form?	Yes. See Appendix 1. (No link available.)	Yes. See Appendix 2. (No link available.)	Yes. The form is **linked here** and in Appendix 3.	Yes, the form is **linked here** and in Appendix 4.	Yes, the form is **linked here** and in Appendix 5.
Form instructions	Patient must complete and sign the form to give authority to the provider's office to set up shipment and schedule delivery on patient's behalf.	Patient must complete and sign the form to give authority to the provider's office to set up shipment and schedule delivery on patient's behalf.	Patient must complete and sign the form to give authority to the provider's office to set up shipment and schedule delivery on patient's behalf.	Patient must complete and sign the form to give authority to the provider's office to set up shipment and schedule delivery on patient's behalf.	Provider completes the form. Patient does not need to complete or sign the form.
How often must patient consent be obtained for medication delivery?	Signatory consent is required for initial prescription. Provider's office handles refills.	Signatory consent is required for initial prescription. Provider's office handles refills.	Signatory consent required at every visit for each subsequent delivery.	Signatory consent is required for initial prescription. Provider's office handles refills.	The prescription acts as consent. No additional verbal or signatory consent required.
Benefit	Pharmacy and Medical	Pharmacy	Medical	Medical	Pharmacy
Contact	Maressa Nordstrom, Senior Clinical Strategist NordstromM1@ aetna.com	Aharon Levi, Pharmacist Program Manager aharon.levi@ anthem.com	Erin Keaveney, Horizon Network Supervisor Erin_Keaveney@ HorizonBlue.com	*Unable to provide*	Please call 800-511-5144

About specialty pharmacies

Specialty pharmacies focus on high cost, high touch medication therapy for patients with complex disease states. Medications in specialty pharmacies range from oral to cutting edge injectable and biologic products. The disease states treated range from cancer, multiple sclerosis, and rheumatoid arthritis to rare genetic conditions.

You can only obtain Sublocade from specialty pharmacies licensed in New Jersey (although they do not need to be physically located be in New Jersey). **Indivior**, the manufacturer of Sublocade, has representatives that support clinics in setting up a Sublocade program, as well as finding specialty pharmacies to work with.

Specialty pharmacies and MCOs

Each MCO in New Jersey has an MCO-affiliated specialty pharmacy with a slightly different process for accessing Sublocade (as we described above). MCOs can also contract with other specialty pharmacies for the distribution of Sublocade (as we discuss in the following pages).

When searching for a specialty pharmacy that best suits your needs, consider asking these questions:

- *What insurances do you work with?*
- *Do you accept electronic prescriptions? If so, are there any specific requirements for electronic prescriptions?*
- *What is your patient consent process for medication delivery?*

Review the impact of pharmacy benefit vs medical benefit:

Sublocade as a pharmacy benefit may be a barrier for patients if they also have prescriptions for other MATs, which often also run as a pharmacy benefit. For example, if someone is prescribed Subutex and Sublocade simultaneously, it may flag as a duplication therapy or "safety edit" by the pharmacy. If this is the case, the provider may have to provide clinical rationale to the pharmacy to ensure the prescriptions is cleared, including mentioning that the treatment plan was specified by the provider and it may take a while for patients to get to a therapeutic level; the pharmacy may be able to override the flag for about 6 months as a result.

Can other specialty pharmacies dispense Sublocade?

There may be other specialty pharmacies in your area that can dispense Sublocade. These pharmacies can fill Subclade if they have a prescription and a contract with specific MCOs.

Aetna

Pharmacy Name	Pharmacy Address	City	State	Zip Code	Phone Number
Accredo Health Group Inc	1620 Century Center Pkwy #109	Memphis	TN	38134	901-385-3600
Caremark Specialty Pharmacy	800 Biermann Ct Ste B	Mountn Prospect	IL	60056	847-634-7400
Banks Apothecary	3800 Horizon Blvd Ste 103	Trevose	PA	19053	215-494-9403
Orsini Pharmaceutical Services	1107 Nicholas Blvd	Elk Grove Villa	IL	60007	847-734-7373
CVS Specialty	105 Mall Blvd	Monroeville	PA	15146	800-238-7828
Genoa Healthcare LLC	93 W Palisade Ave	Englewood	NJ	07631	201-627-4407

Note: Giannotto's Pharmacy in Newark, NJ dispenses Sublocade for ABHNJ but is not registered as a specialty pharmacy with CVS.

Amerigroup

These are the following specialty pharmacies Amerigroup has contracts with to dispense Sublocade in New Jersey:

Pharmacy Name	Pharmacy Address	City	State	Zip Code	Phone Number
Orsini Pharmaceutical Services	1107 Nicholas Blvd	Elk Grove Village	IL	60007	847-734-7373
Caremark Specialty Pharmacy	180 Passaic Ave	Fairfield	NJ	07004-3516	973-461-1550
Carepak Pharmacy	105 Challenger Rd Ste 401	Ridgefield Park	NJ	07660-2101	201-225-0057
Genoa Healthcare LLC	93 W Palisade Ave Rm 128	Englewood	NJ	07631-2611	201-627-4407
Genoa Healthcare LLC	1259 Route 46 Bldg 2 Ste 100A	Parsippany	NJ	07054	973658--6685
Giannottos Pharmacy	195 1st Ave W	Newark	NJ	07107-2618	973-482-8220
Chem Rx Pharmacy Services	51 Charles Lindbergh Blvd	Uniondale	NY	11553	516-536-0800
Banks Apothecary	3800 Horizon Blvd Ste 103	Trevose	PA	19053	215-494-9403
CVS Specialty	105 Mall Blvd	Monroeville	PA	15146-2230	800-238-7828

Horizon

A specialty pharmacy can dispense Sublocade to Horizon members if they have a **contract with Horizon**.

Pharmacy Name	**Phone Number**
Accredo Health Group Inc.	866-515-1437
Advanced Pharmacy Solutions	949-348-7900
AllianceRx Wallgreens Pharmacy	866-823-9575
Amber Specialty Pharmacy	888-370-1724
Banks Apothecary	215-494-9403
Bergen Pharmacy	888-712-3302
BioPlus Specialty Pharmacy	866-841-4714
BioTek ReMEDys	877-246-9104
CVS Caremark Specialty Pharmacy	800-237-2767
Ethical Factor Rx	570-606-3622
Giannottos Pharmacy	855-442-6668
Hy-Vee Pharmacy Solutions	877-794-9833
Infucare Rx of MD	844-733-6779
Lee Pharmacy 7	239-468-0090
Lifeline Specialty Pharmacy	410-203-1010
New York-Presbyterian-Queens	718-670-1728
NYU Langone Pharmacy, Cobble Hill	877-698-2330
Optum Pharmacy	855-427-4682
PharmaPlus Pharmacy	732-370-4777
Premier Pharmacy Services	800-540-4700
Pyramids Specialty Pharmacy	346-374-7358
Qualitas Pharmacy Services	800-242-0113
Schraft's 2.0	855-724-7238
Senderra Rx Pharmacy	888-777-5547
SOMC Pharmacy Wheelersburg	740-355-4120
Summa Health Akron Retail Pharmacy	330-375-4911
Synergen Rx, LLC	404-585-7517
The Mount Sinai Hospital	212-241-7720
Twelvestone Medical, Inc	844-893-0012
Walmart Pharmacy 10-5315	877-453-4566

United

These are the following specialty pharmacies United has contracts with to dispense Sublocade in New Jersey:

Vendor	**Phone Number**	**Fax**	**Website**
Accredo	866-759-1557	888-302-1028	**www.accredohealth.com**
Genoa	800-519-1139	253-218-0336	**http://optioncare.com**
Optum Specialty	855-427-4682	877-342-4596	
Orsini Pharmaceutical Services	800.410.8575	847.879.9551	

Wellcare

A specialty pharmacy can dispense Sublocade to Wellcare members if they have a **contract with Wellcare**.

Pharmacy Name	**Phone Number**
AcariaHealth Pharmacy	1-844-538-4661
Accredo Health Group	1-866-718-7952
Optum Specialty Pharmacy	1-877-546-5779
CVS Caremark Specialty Pharmacy	1-800-237-2767
Walgreens Specialty Pharmacy	1-888-782-8442

Additional resources

Centers of Excellence (CoE):

The Centers of Excellence offer provider supports for MAT providers across the state. We encourage providers to utilize the **OBAT provider manual** for best practices in providing MAT, example templates, and other resources.

- *Provider Hotline:*
  - *24/7 access to advice from MAT experts for providers who have any clinical questions about MAT.*
  - *Call or text 1-844-HELP-OUD (1-844-435-7683)*
- ***Northern NJ MAT Center of Excellence website***
- ***Southern NJ MAT Center of Excellence website***

OBAT trainings

The state is providing training for OBAT navigators at no cost. Providers interested in this training can call the State's Office of Behavioral Health at 609-631-4641 for more information.

Appendices: MCO Sublocade enrollment forms

Appendix 1 – Aetna

CVS specialty®

aetna
Aetna Better Health® of New Jersey

Sublocade Enrollment Form for AETNA NJ Medicaid Only

Fax Referral To: 1-800-323-2445 | Phone: 1-866-823-5179 | Email Referral To: Customer.ServiceFax@CVSHealth.com

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Patient must complete highlighted area) **Scheduled Injection Date:** _____

Patient Name: _____ Address: _____

City, State, ZIP Code: _____ DOB: _____ Last Four of SSN: _____ Gender: ☐ Male ☐ Female

Primary Phone: _____ Alternate Phone: _____ Email: _____

By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account and health care. Standard data rates apply. Message frequency varies.

Designated Patient Contact

By signing below, I authorize my Contact, listed below, to receive logistical and administrative information related to my treatment, including ability to make decisions on my behalf, for which I will remain liable, regarding delivery of Sublocade (buprenorphine extended-release injectable). CVS Specialty is not liable for any decision(s) made by the Contact or actions taken in reliance on such Contact decisions. Please list any authorized Contact as set forth above:

Contact Name: _____ Relationship: _____ Phone: _____

Patient's Signature: _____ **Date:** _____

Patient Authorization

I hereby authorize CVS Specialty to contact my prescribing provider, on my behalf, to coordinate the delivery, receipt and storage of my Sublocade prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. I further authorize CVS Specialty and its affiliates to share this form with my prescribing provider. I understand that my signature below serves as the Patient Ship Authorization, which means the pharmacy will not outreach/contact me and/or my designated contact on this form, prior to shipping medication except in certain circumstances.

Patient's Authorization: _____ **Date:** _____

CVS Specialty may contact patient and/or patient's designee in the event the patient's copay/coinsurance responsibility is greater than $50.

2 PRESCRIBER INFORMATION

Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Facility ☐ Correctional

Prescriber's First Name: _____ Prescriber's Last Name: _____ NPI#: _____

State License#: _____ DEA#: _____ XDEA#: _____

Practice/Facility Name: _____ Practice NPI#: _____

Practice Address (Ship to Address): _____ City: _____

State/ZIP Code: _____ Phone Number: _____ Fax Number: _____

Office Contact Name: _____ Contact's Phone: _____

Note: The pharmacy will only ship to the address registered with the DEA, associated with the DEA# provided above.

3 INSURANCE INFORMATION (Please fax copy of prescription/medical insurance cards with this form, front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No

Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Telephone: _____

Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

☐ Check box if patient is enrolled in manufacturer copay assistance. If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION (to be completed by prescriber only)

Allergies: _____ Has patient previously been treated for Opioid Use Disorder? ☐ Yes ☐ No

If yes, list all previous medications:

_____

List concomitant medications (e.g., adjunctive depression medications, sedative hypnotics, psychostimulants):_____

_____

_____

Diagnosis (ICD-10):	
☐ F11.2 Opioid dependence	☐ F11.24 With opioid-induced mood disorder
☐ F11.20 Opioid dependence, uncomplicated	☐ F11.25 Opioid dependence with opioid-induced psychotic disorder
☐ F11.21 Opioid dependence, in remission	☐ F11.28 Opioid dependence with other opioid-induced disorder
☐ F11.22 Opioid dependence with intoxication	☐ F11.29 With unspecified opioid-induced disorder
☐ F11.23 Opioid dependence with withdrawal	☐ Other Code: _____ Description: _____

Sublocade Enrollment Form for AETNA NJ Medicaid Only

5 PRESCRIPTION INFORMATION (to be completed by prescriber only)

Because of the risk of serious harm or death that could result from intravenous self-administration, **Sublocade is only available through a restricted program called the Sublocade Risk Evaluation and Mitigation Strategy (REMS) Program**. Health care settings and pharmacies that order and dispense Sublocade must be certified in this program and comply with the REMS requirements. Sublocade should only be prepared and administered by a licensed health care provider.

NOTE: *Prescriber must comply with their state-specific prescription requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element that may be required and that is not captured by this form. For this reason, the prescription form below should only be used if permitted by the applicable law in your state. The prescriber should include all required elements of a controlled substance prescription.*

Patient Name (First and Last): _____ Patient Date of Birth: _____

Patient Address: _____

Drug Name, Strength and Dosage Form: _____

Directions/Sig: _____

Quantity Authorized (Numeric): _____ (Written): _____

Prescriber Name: _____ Prescriber Phone Number:_____

Prescriber DEA #:_____ State License #: _____

Prescriber Address: _____

Supervising Physician Name: _____ Supervising Physician Phone Number:_____

Supervising Physician Address: _____ Supervising Physician DEA#: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

May Substitute/Product Selection Permitted/ Substitution Permissible	Dispense As Written/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/ May Not Substitute
Prescriber's Signature: _____ **Date:** _____	**Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**"

ATTN: New York and Iowa providers, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

I have obtained written authorization from the Patient to disclose the Patient's personal health information and any other information on this enrollment form as may be required to comply with all applicable federal and state laws and regulations, including, but not limited to, the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164) and the Confidentiality of Substance Use Disorder Patient Records Regulation (42 C.F.R. Part 2), as amended from time to time.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.

CVS specialty®

Sublocade Enrollment Form

Fax Referral To: 1-800-323-2445 | Phone: 1-866-823-5179 | Email Referral To: Customer.ServiceFax@CVSHealth.com

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Patient must complete highlighted area)

Scheduled Injection Date: _____

Patient Name: _____ Address: _____

City, State, ZIP Code: _____ DOB: _____ Last Four of SSN: _____ Gender: ☐ Male ☐ Female

Primary Phone: _____ Alternate Phone: _____ Email: _____

By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account and health care. Standard data rates apply. Message frequency varies.

Designated Patient Contact

By signing below, I authorize my Contact, listed below, to receive logistical and administrative information related to my treatment, including ability to make decisions on my behalf, for which I will remain liable, regarding delivery of Sublocade (buprenorphine extended-release injectable). CVS Specialty is not liable for any decision(s) made by the Contact or actions taken in reliance on such Contact decisions. Please list any authorized Contact as set forth above:

Contact Name: _____ Relationship: _____ Phone: _____

Patient's Signature: _____ **Date:** _____

Patient Authorization

I hereby authorize CVS Specialty to contact my prescribing provider, on my behalf, to coordinate the delivery, receipt and storage of my Sublocade prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. I understand that my signature below serves as the Patient Ship Authorization, which means the pharmacy will not outreach/contact me and/or my designated contact on this form, prior to shipping medication except in certain circumstances.** I further agree to pay to CVS Specialty any required copayment or coinsurance amount, up to a total amount of $50, without prior outreach to me or my designated contact.

Patient's Authorization: _____ **Date:** _____

***CVS Specialty may contact patient and/or patient's designee in the event the patient's copay/coinsurance responsibility is greater than $50. Enrollment above is not available to Medicare and Medicaid patients because government payors are excluded from this offering. Copayment, copay or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.*

2 PRESCRIBER INFORMATION

Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Facility ☐ Correctional

Prescriber's First Name: _____ Prescriber's Last Name: _____ NPI#: _____

State License#: _____ DEA#: _____ XDEA#: _____

Practice/Facility Name: _____ Practice NPI#: _____

Practice Address (Ship to Address): _____ City: _____

State/ZIP Code: _____ Phone Number: _____ Fax Number: _____

Office Contact Name: _____ Contact's Phone: _____

Note: The pharmacy will only ship to the address registered with the DEA, associated with the DEA# provided above.

3 INSURANCE INFORMATION (Please fax copy of prescription/medical insurance cards with this form, front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No

Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Telephone: _____

Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION (to be completed by prescriber only)

Allergies: _____ Has patient previously been treated for Opioid Use Disorder? ☐ Yes ☐ No

If YES, list all previous medications: _____

List concomitant medications (e.g., adjunctive depression medications, sedative hypnotics, psychostimulants): _____

Diagnosis (ICD-10):	
☐ F11.2 Opioid dependence	☐ F11.24 With opioid-induced mood disorder
☐ F11.20 Opioid dependence, uncomplicated	☐ F11.25 Opioid dependence with opioid-induced psychotic disorder
☐ F11.21 Opioid dependence, in remission	☐ F11.28 Opioid dependence with other opioid-induced disorder
☐ F11.22 Opioid dependence with intoxication	☐ F11.29 With unspecified opioid-induced disorder
☐ F11.23 Opioid dependence with withdrawal	☐ Other Code: _____ Description: _____

Sublocade Enrollment Form

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Because of the risk of serious harm or death that could result from intravenous self-administration, **Sublocade is only available through a restricted program called the Sublocade Risk Evaluation and Mitigation Strategy (REMS) Program**. Health care settings and pharmacies that order and dispense Sublocade must be certified in this program and comply with the REMS requirements. Sublocade should only be prepared and administered by a licensed health care provider.

NOTE: *Prescriber must comply with his/her state-specific prescription requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form below should only be used if permitted by the applicable law in your state. The prescriber should include all required elements of a controlled substance prescription.*

Patient Name (First and Last): _____ Patient Date of Birth: _____

Patient Address: _____

Drug Name, strength, and dosage form: _____

Directions/Sig: _____

Quantity Authorized (Numeric): _____ (Written): _____

Prescriber Name: _____ Prescriber Phone Number: _____

Prescriber DEA #: _____ XDEA #: _____ State License #: _____

Prescriber Address: _____

Supervising Physician Name: _____ Supervising Physician Phone Number: _____

Supervising Physician Address: _____ Supervising Physician DEA#: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

May Substitute/ Product Selection Permitted / Substitution Permissible	Dispense As Written/ Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: _____ **Date:** _____	**Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**"

ATTN: New York and Iowa providers, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

I have obtained written authorization from the Patient to disclose the Patient's personal health information and any other information on this enrollment form as may be required to comply with all applicable federal and state laws and regulations, including, but not limited to, the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164) and the Confidentiality of Substance Use Disorder Patient Records Regulation (42 C.F.R. Part 2), as amended from time to time.

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Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.

Please fax both pages of completed form to your drug therapy team at 888.302.1028.

To reach your team, call toll-free 844.412.4764.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Sublocade® (buprenorphine extended-release) injection CIII

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

☐ Male ☐ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/clinic/institution name _____ Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Deliver product to: ☐ Office ☐ Clinic Clinic location _____

3 Clinical Information

Primary ICD-10 code required: _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Prescription & Enrollment Form: Sublocade® (buprenorphine extended-release) injection CIII **Fax completed form to 888.302.1028.**

Patient's first name _____ Last name _____ Middle initial ____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

	Medication	Strength/Formulation	Directions	Quantity/Refills
☐ Loading dose ☐ Maintenance dose				Quantity Refills

- Prescription use of this product is limited by the Drug Addiction Treatment Act (DATA) to prescribers who are authorized to treat opioid dependence and are DATA 2000-waivered.
- Sublocade® will only be shipped to the prescriber's healthcare setting address as registered on their DEA registration.
- Sublocade can only be obtained through REMS-certified pharmacies; please visit **www.SublocadeREMS.com** for more information.
- All prescriptions for Sublocade should be sent directly to the REMS-authorized dispensing pharmacy. For patient support and program information, please visit the manufacturer's product support website **www.Sublocade.com**.
- Provide literature from the shipment to the patient; retain the patient-signed refill form to coordinate next refill.

XDEA number required		**DEA number required**	

I hereby authorize Accredo to contact my prescribing provider to coordinate the delivery, receipt and storage of my Sublocade prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.	Patient authorization

Further patient copay responsibility over $50 may result in an outreach to the patient to obtain authorization.

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

Date	**Dispense as written**	**Date**	**Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

accredo®

Optum

Phone: 855-427-4682
Fax: 844-232-7205

Sublocade™ (buprenorphine extended-release) Injection CIII enrollment form

(please use black ink)

Specialty Pharmacy Enrollment Form ✂ Please detach before submitting to a pharmacy - tear here. **This form is not a valid prescription in Arizona**

Patient information

Please complete the following or send patient demographic sheet

Patient name _____
Address _____
Address 2 _____
City, State, ZIP _____
Home phone _____ Alternate phone _____
DOB _____ Gender _____
SS#/Drivers license# or State issued ID (Where applicable per state law)
_____
Language preference: ☐ English ☐ Spanish ☐ Other _____

Prescriber information

Prescriber's name _____
DEA _____
NPI _____
State license _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact person _____ Phone _____

Insurance information *(Fill out entirely or fax a copy of patient's insurance card including both sides)*

Prior authorization reference number _____

Medical information (Section must be completed to process prescription) *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ F11.20 Opioid dependence, uncomplicated
☐ F11.21 Opioid dependence, in remission
☐ Other: ICD-10 _____ Description _____

Allergies/Comments _____
Concomitant medications _____
Weight _____ kg / lbs Height _____ cm / in BMI _____

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

Select medication doses		Medication	Dose/Strength	Directions	Quantity	Days supply	Refills
☐	Loading dose						
☐	Maintenance dose						

- Sublocade™ may only be delivered to a healthcare setting and is NEVER dispensed to a patient directly.
- Sublocade™ can only be obtained through REMS-certified pharmacies; please visit www.SublocadeREMS.com for more information.
- All prescriptions for Sublocade™ should be sent directly to the REMS-authorized dispensing pharmacy. For patient support and program information, please visit the manufacturer's product support website sublocade.com.
- Optum Rx is REMS-certified and REMS authorized dispensing pharmacy.

Provider shipping information

- Office contact: _____
- Phone: _____
- Shipping address: _____
- Date medication needed: _____
- Faxed by: _____

This form is provided as a convenience to prescribers. The pharmacy acknowledges that this form may not meet requirements for a valid prescription in every state. Prescriber are obligated to comply with the state-specific prescription requirements in the state where the prescription is issued, including, but not limited to, e-prescribing, state-specific prescription forms, and fax language. The pharmacy will contact prescribers for clarification on any prescription that does not meet state-specific requirements in the state where it is issued.

I authorize Optum* Specialty Pharmacy to bill my insurance company for this prescription and refills of this prescription. I understand that I am financially responsible for any co-pay/co-insurance amounts or other amounts not covered by my insurance. I understand that either I or my authorized representative will need to contact Optum* Specialty Pharmacy if there are changes in my insurance or I no longer need this prescription. I authorize this prescription and all refills of this prescription to be shipped to my physicians office at the address below.

Physicians name _____ Address 1 _____
Signature of patient or patient's authorized representative _____ Address 2 _____

This prescription is valid only if transmitted by facsimile from the prescriber's office.

***Prescriber authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date _____ Supervising Physician _____ Date _____

Electronically signed faxed prescriptions are not acceptable. A manual signature of the prescriber is required.

3188 020823

Appendix 5 – Wellcare

AcariaHealth
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 855.423.4624

Date Shipment Needed: _____
MUST Ship To: DEA Registrant Address

SUBLOCADE REFERRAL FORM

PATIENT INFORMATION							
Patient Name:			DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.	
SSN:	Phone:	Allergies:					
Address:			City:	State:	Zip:		
Emergency Contact:		Phone:		❑**Please attach demographic information**			
PRESCRIBER INFORMATION							
Prescriber:			NPI:	State Lic:			
Supervising Physician:			Practice Name:				
Address:			City:	State:	Zip:		
Phone:	Fax:		Key Office Contact:	Phone:			
DEA REGISTRATION							
DEA:	XDEA:		Phone:				
Address:			City:	State:	Zip:		
DIAGNOSIS INFORMATION / MEDICAL ASSESMENT							
Primary Diagnosis: (ICD-10 Code & Description) _____							
▪ Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): _____							
▪ Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____							
▪ Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____							
INSURANCE INFORMATION							
❑**Please attach front and back of patient's insurance card (medical and prescription)**							
COPAY CARD ENROLLMENT							
❑**Please check if enrolling in copay card**			Copay ID:				
PRESCRIPTION INFORMATION							
Drug Name							
❑**Starter Dose** ❑**Starter Dose not needed**	Strength/Formulation:		Directions:		QTY: ____ Refills:____		
❑**Maintenance Dose**	Strength/Formulation:		Directions:		QTY: ____ Refills:____		
*For abdominal subcutaneous injection only. Do not administer intravenously or intramuscularly.							

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank.

About the Camden Coalition

We are a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. The Camden Coalition works to advance the field of **complex care** by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and well-being. Supported by a robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver better care to the most vulnerable individuals **in Camden** and **regionally**.

Through our **National Center for Complex Health and Social Needs** (National Center), an initiative of the Camden Coalition, we connect complex care practitioners with each other and support the field with tools and resources that move complex care forward.