POLARIS SPECIALTY RX

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Polaris Specialty Pharmacy
410 Cloverleaf Drive
Baldwin Park, CA 91706
NPI: 1053486795

SUBLOCADE ENROLLMENT FORM

All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Patient Name: ______________________ DOB: ____________ SSN: ______________

Address: ____

City: ______________________ State: __________ Zip: ____________

Phone: ______________________ Alt Phone: ______________________

Email: ____

Alternate Contact Info: ____

Allergies: ____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical Information

Diagnosis
☐ F11.20 Opioid Dependence, uncomplicated
☐ F11.20 Opioid Dependence, in remission

Other: ______________________________

Current status of Sublocade:
☐ New to therapy ☐ Restarting therapy
☐ Currently on therapy: Dose/Date of last injection: _________mg on ____________

Has patient been stable on a minimum daily dose of 8 mg of transmucosal buprenorphine for at least 7 days? ☐ Yes ☐ No

Is patient taking benzodiazepines, tramadol, carisoprodol, or opioids? ☐ Yes ☐ No If yes, please list: ______________________

____

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Prescription Information

PRESCRIBER MUST E-SCRIBE SUBLOCADE TO POLARIS SPECIALTY PHARMACY LOCATED AT 410 CLOVERLEAF DRIVE, BALDWIN PARK, CA 91706 (NPI: 1053486795)
Sublocade may only be shipped to the DEA registered address. Sublocade may not be shipped to a patient's home or handed to a patient to take home. Sublocade may only be administered subcutaneously by the administering practitioner.

☐ Sublocade has been e-scribed.
Please note that verbal and fax orders will not be accepted as valid prescriptions. If you cannot e-scribe, please call the pharmacy at 800-540-4700 and speak with a pharmacist.

DOSING REFRENCE

Loading Dose: Sublocade 300mg subcutaneously every month for 2 months.
Maintenance Dose: Sublocade 100mg subcutaneously every month thereafter.

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: ______________________ NPI: ____________ DEA: ____________ LIC#: ____________

DEA Registered Address: ____

City: ______________________ Zip: ________ Tel: ________________ Fax: ________________

Contact Person: ______________________________ E-Mail: ______________________________

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.

I authorize Polaris Specialty Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: ______________________________ ☐ **Dispense as written (DAW) Date:** ______/______/______

IMPORTANT NOTICE: 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 is not a valid prescription. All prescriptions must be submitted via e-script to: Polaris Specialty Pharmacy, 410 Cloverleaf Dr., Baldwin Park, CA 91706 (NPI: 1053486795)