ST. MATTHEWS SPECIALTY PHARMACY

FAX: 844-524-HOPE (4673)
Phone: 844-690-4462

SUBSTANCE USE DISORDER FORM

Need By Date: ___/___/___ SHIP TO: ☐ Office ☐ Other _____ Pharmacy to Inject ☐

PATIENT INFO

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Social Security# _____ DOB: _____
Height: _____ Weight: _____
Alternate Contact: _____ Phone: _____

PROVIDER INFO

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
License # _____
Contact Person: _____ Sp# _____

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

Diagnosis/Clinical information | Please FA recent clinical notes, Labs, Tests, with the prescription to expedite the Prior authorization

Diagnosis: ❑ Alcohol dependence, maintenance of abstinence ❑ Opioid Dependence, Relapse following detoxification; prophylaxis

ICD-10: _____ Allergies: _____

PRESCRIPTION INFORMATION:

Medication	Dosage & Strength	Direction	QTY	Refills
☐ VIVITROL	380mg vial	Inject 380mg once every 28 days	1	11
☐ NALTREXONE	50mg tablet	Take 50mg tablet by mouth *first time dose	1	0
☐ EVZIO	2 mg Auto-Injector	Auto-inject into outer thigh. "CALL 911** Provide CPR or rescue breaths. Repeat with 2nd injector in 2-3 mins. if necessary.	2	0
☐ NARCAN	Nasal 4mg/0.1 mL Spray	Spray into nostril upon signs of opioid overdose. CALL 911. Repeat x 1 in 3 min. if necessary.	2	0
☐ LUCEMYRA	0.18mg tablet	Take 3 tablets by mouth four times a day for 7 days, then 2 tablets by mouth four times a day for 1 day, then 1 tablet by mouth four times a day for 1 day	96	0

Prescriber Authorization: I authorize St. Matthew's Specialty 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 to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature _____ Today's Date: / /

Patient Authorization: I authorize St. Matthews 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 St. Matthew's Specialty Pharmacy if there are changes in my insurance or I no longer need this prescription

I allow my prescriber to be my authorized individual and may order my prescription refills / schedule delivery or pickup of my prescription

I understand I have an offer for prescription counseling by the pharmacist but decline the offer of counseling at this time.

Physician's Name _____ Address 1 _____

Patient's Signature _____ Address 2 _____

Revised 6/11/19