ST. MATTHEWS SPECIALTY PHARMACY

Fax: 844-524-4673 | Phone: 844-690-4462

SUBSTANCE USE DISORDER FORM

Need By Date: ____/____/____ SHIP TO: ☐ Office ☐ Other_____

PATIENT INFO

Name:_____

Address:_____

City:_____ State:____ ZIP:_____

Phone:_____ Alt Phone:_____

SSN:_____ DOB:_____

Height:_____ Weight:_____

Alternate Contact:_____ Phone:_____

PROVIDER INFO

Name: _____

Address: _____

City:_____ State:____ ZIP:_____

Phone:_____ Alt Phone:_____

NPI:_____ DEA:_____

License #:_____

Contact Person:_____ Sp#:_____

PLEASE FAX COPY OF PRESCRIPTION CARD AND MEDICAL CARD FRONT AND BACK

Diagnosis/Clinical Information | Please FAX recent clinical notes, labs and tests with the prescription to expedite the prior authorization

Select Diagnosis Code (ICD-10): ☐ Alcohol dependence, maintenance of abstinence (F10.20)

☐ Opioid Dependence, Relapse following detoxification; prophylaxis (F11.20) ☐ Other_____

List patient medication allergies: _____

PRESCRIPTION INFORMATION

Medication	Dosage & Strength	Directions	Qty	Refills
☐ VIVITROL	380mg vial	Inject 380mg intramuscularly (IM) once every 28 days	1	11
☐ NALTREXONE	50mg tablet	Take 50mg tablet by mouth *first time dose	1	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

Prescriber Authorization: I hereby authorize St. Matthews Specialty Pharmacy to complete and submit prior authorization ("PA") requests to payors for the prescribed medication for this patient, to attach supporting documentation provided by my office, and to attach this form to the PA request as my signature.

Prescriber's Signature:_____ **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. Matthews Specialty Pharmacy if there are changes in my insurance or I no longer need this prescription.

I authorize St. Matthews Specialty Pharmacy to disclose protected health information to third parties, including insurance carriers, pharmacy benefit managers, pharmaceutical manufacturers, or their agents, as necessary to secure PA for the prescribed medication.

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 and may contact the pharmacy for such counseling in the future but decline the offer of counseling at this time.

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

Revised 7/15/21