St. Matthews Specialty Pharmacy

FAX: 844-524-4673 | PHONE: 844-690-4462
EMAIL: BRIXADI@stmatthewsrx.com
ENROLLMENT FORM IS NOT A PRESCRIPTION

BRIXADI ENROLLMENT FORM

Injection Date: __/__/____ **FACILITY NAME:**

SELECT FACILITY TYPE: ☐ Provider Office ☐ Outpatient Treatment Facility ☐ Inpatient ☐ Other _____

PATIENT INFO

Name: _____
Address: _____
City: _____ State: ____ ZIP: _____
Phone: _____ Cell Phone: _____
SSN: _____ DOB: _____
Alternate Contact: _____ Phone: _____
☐ NKDA ☐ Allergies: _____

ORDERING PRESCRIBER INFO

Name: _____ Select one: ☐ MD ☐ DO ☐ PA ☐ APRN
DEA Registered Address: _____
City: _____ State: ____ ZIP: _____
Phone: _____ Alt Phone: _____
NPI: _____ DEA: _____
License #: _____ Contact Person: _____
Email: _____ Contact #: _____

SEND COPY OF PATIENT PRESCRIPTION & MEDICAL CARD (FRONT & BACK), MEDICATION LIST, CLINIC NOTE

DIAGNOSIS / CLINICAL INFORMATION

Primary Diagnosis (ICD10 Code): _____
☐ Patient is enrolled in Brixadi Copay Savings Program - Copay ID#: _____

Status of current treatment with Brixadi:

☐ New to Brixadi therapy
- ☐ No prior exposure to sublingual (SL) buprenorphine therapy and will be treated with ≥ 1 dose before Brixadi
- ☐ Currently being treated with a buprenorphine-containing product. List medication below.
  Drug Product (oral or injectable): _____ Dose: _____ Last Injection Date (if applicable): _____

☐ Currently on Brixadi therapy. Dose / Last Injection Date: _____mg on _____

Patient on other medication(s)? ☐ Yes, Med List attached ☐ No, patient is taking no other medication(s)

PRESCRIBING INFORMATION (Call Pharmacy if e-scribing unavailable)

PRESCRIBER MUST E-SCRIBE BRIXADI to ST. MATTHEWS SPECIALTY PHARMACY. BRIXADI may only be shipped to a DEA registrant address. BRIXADI may not be shipped to a patient's home or redistributed (handed) to a patient to take home. BRIXADI may only be injected via subcutaneous route by the administering practitioner.

☐ **BRIXADI** has been e-scribed

For weekly dosing only: May order up to a 4-week supply per prescription. No less than 2 weeks supply recommended, as deemed clinically appropriate.

☐ **Emergency Opioid Reversal Drug** has been e-scribed to arrive with Brixadi (ex: naloxone, nalmafene)

BRIXADI Dosing Reference

SL Daily Dose	BRIXADI (weekly)	BRIXADI (monthly)
≤ 6 mg	8 mg	N/A
8-10 mg	16 mg	64 mg
12-16 mg	24 mg	96 mg
18-24 mg	32 mg	128 mg

Patient Authorization: I hereby authorize St. Matthews Specialty Pharmacy to contact my prescribing provider to coordinate the delivery, receipt, and storage of my BRIXADI prescription medication for the sole purpose of administration by an authorized provider. I understand that my signature below serves as Patient Ship Authorization. I authorize St. Matthews Specialty Pharmacy to bill my insurance company for this prescription and refills. 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 the Pharmacy if there are changes in my insurance or no longer need this prescription. I or my authorized representative authorize the release of my personal health information and any other information on this enrollment form to third parties, including payors, pharmacy benefit managers, distributors, or their agents, as may be required to investigate, authorize and/or fill my prescription.

PATIENT Signature: _____ **Date:** __/__/__

_____**(patient initials)** I understand I have an offer for prescription counseling by the pharmacist and decline counseling at this time but understand that I may contact the pharmacy for counseling at any time in the future.

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, where allowable by law.

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.

PRESCRIBER Signature: _____ **Date:** __/__/__