Phone: (844) 431-7277

Fax: (844) 432-7277

Please submit an electronic prescription together with the enrollment form

Brixadi®

For pharmacy locations, please scan QR code

Specialty Pharmacy Services Enrollment Form

PATIENT INFORMATION

Patient First Name:	Patient Last Name:	DOB:	Sex at Birth: M F	Weight:	Height:	Diabetic: Y N

Address:	Allergies:

City:	State:	Zip Code:	Cell Phone:	Work/Home:

HIPAA Contact:	Emergency #:	Interpreter Needed: Y N

PRESCRIBER INFORMATION

Prescriber Name:	MD DO NP PA	NPI:

DEA:	Supervising Physician Name, if applicable:

Office Address:	City:	State:	Zip:

Phone:	Fax:	Office Contact Name:

Alternate Sites of Care (ASOC) DEA#:	ASOC Brixadi REMS ID#	ASOC Contact Name and Phone Number:

NOTE: BRIXADI orders cannot be fulfilled unless the shipping address matches the registered address on file with the DEA

PATIENT INSURANCE INFORMATION: PLEASE SEND COPY OF INSURANCE CARD

Primary Insurance:	Policy ID:	Group #:

Policyholder Name and DOB:	BIN AND PCN:	If applicable, Brixadi Copay Savings Program Copay ID:

CLINICAL INFORMATION: PLEASE SEND COPY OF PROGRESS NOTES AND LAB REPORTS SUPPORTING DIAGNOSIS

ICD-10/Diagnosis Code: F11.20 Opioid Dependence, Uncomplicated F11.21 Opioid Dependence, in remission Other:

Allergies:	Concomitant Medications:

Prior Buprenorphine Therapy:

Date of Diagnosis:	Scheduled Injection Date:	Deliver To: Prescriber Office Other Office:

PRESCRIPTION INFORMATION I PLEASE SEND VALID ELECTRONIC PRESCRIPTION ALONGSIDE ENROLLMENT FORM. THIS FORM IS NOT A VALID PRESCRIPTION.

Select Medication Dose	Frequency	Medication	Dose/Strength	Administration	Quantity	Day Supply	Refills
○	Weekly	Brixadi	8 mg/0.16mL 16 mg/0.32 mL 24 mg/0.48 mL 32 mg/0.64 mL	Administer SQ every 7 days	1	7	
○	Monthly	Brixadi	64 mg/0.18mL 96 mg/0.27 mL 128 mg/0.36 mL	Administer SQ every 28 days	1	28	

There are limitations to the logistics of supplying BRIXADI that could jeopardize continuity of care (eg, unanticipated shipment delays). We recommend prescribing sufficient BRIXADI supply to last 2 weeks if you deem it appropriate.

Additional Instructions:

By signing this form and utilizing our services, you are authorizing Price Chopper Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature:	**Date Issued:**	**Prescriber Signature:**	**Date Issued:**
Substitution Permitted		**Dispense As Written**	

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