Faxed prescriptions will only be accepted by a prescribing practitioner. Prescribers are reminded patients may select the pharmacy of their choice.

altScripts Specialty Pharmacy

AODA and SUD Referral Form

1636 Miller Park Way, West Milwaukee, WI 53214 | Phone: 414-385-9500 | Fax: 414-385-7200 | www.altscripts.com

Patient Information: Please provide a copy of the patient's prescription insurance card (front & back) or information

Patient name:	DOB:	Gender: ☐ F ☐ M ☐ O	HT:	WT:

Address:	City:	State:	Zip Code:	Phone:

Insurance:	Allergies: ☐ NKDA ☐ List allergies:

Clinical Information: Please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis:

Alcohol dependence
- ☐ F10.20 Maintenance of abstinence
- ☐ F10.___ _____
- ☐_____ _____

Opioid dependence
- ☐ F11.20 Relapse following detoxification; prophylaxis
- ☐ F11.23 Opioid Dependence w/Withdrawal
- ☐ F11.93 Opioid Use Unspecified w/Withdrawal

Failed medications (dose and duration): _____

Past Medical History:
- ☐ Patient has a history of noncompliance with oral medications
- ☐ Clinical notes, labs and previous medical history sent to pharmacy

Prescription Information

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Lucemyra®**	0.18 mg tablet	☐ Take 3 tablets PO four times daily for 7 days. Take 2 tablets PO four times daily for 1 day. Take 1 tablet PO four times daily for 1 day and then discontinue. ☐ Take 1 - 4 tablets PO four times daily as guided by symptoms.	☐ 96 tablets ☐ 192 tablets	
☐ **Narcan® Nasal Spray**	4 mg (one unit = 2 sprays)	Administer a single spray into one nostril. Read the package for additional doses.	☐ 1 kit	
☐ **Sublocade® - *REMS***	☐ 100 mg	Inject 100 mg SQ every 4 weeks	☐ 1 kit	
	☐ 300 mg	Inject 300 mg SQ every 4 weeks	☐ 1 kit	
	Administering Provider (if different than below) _____			
☐ **Vivitrol®**	380 mg	Inject 380 mg IM every 4 weeks	☐ 1 kit	
☐ **ZIMHI®**	5 mg/ 0.5 ml	Administer per instructions for use.	☐ 1 kit	

Prescriber Information

Prescriber name:	Phone:	Office contact name:	

Prescriber address:	City:	State:	Zip:

NPI:	DEA:	Fax and/or Email:

Prescriber signature:	Date:	☐ DO NOT SUBSTITUTE