curanthealth
improving outcomes. improving lives.

Fax Sublocade Enrollment Form to: 1-866-427-1464 OR
Email Enrollment Form to: FLintake@curanthealth.com
Fax Sublocade RX to: 1-866-461-8411
Phone #: 1-866-200-0371

Sublocade® Enrollment Form

Please send prescription electronically

Patient Information		
Name:	DOB:	
Sex: ☐ Male ☐ Female	SS#:	
Address:		
City:	State:	Zip Code:
Phone #:	Secondary #:	
Email:	Allergies: write **NONE** if applicable	
Language Preference: ☐ English ☐ Spanish ☐ Other		
Medical Records Number (MRN):		
Emergency Contact:	Contact Phone #:	

Prescriber Information		
Prescriber Name:	Facility Name:	
Address:		
City:	State:	Zip Code:
Office #:	Office Fax #:	
Email:		
State License #:	NPI #:	
DEA #:		
Is Provider a certified Buprenorphine Provider: ☐ YES ☐ NO		

Insurance / Financial Information*	
☐ Private Insurance ☐ Medicaid ☐ Medicare Part D ☐ Other: _____ ☐ Patient Assistance Program	
Insurance Provider:	
Insured's Name:	Relationship to Patient:
Rx Bin #:	Rx PCN #:
Rx ID #	Group or Plan #:
Is Patient 340B eligible: ☐ YES ☐ NO	
Is Patient eligible for PAP (Patient Assistance Program): ☐ YES ☐ NO *If yes, please submit a copy of the PAP application along with this form.	
Is Patient eligible for Clinic Financial Assistance: ☐ YES ☐ NO	
Please include a copy of the front and back of insurance, prescription, and/or co-pay assistance card(s).	

Form Date: 1/20/2023

11001 Roosevelt Blvd • Suite 1400 • St. Petersburg, FL 33716

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Clinical Information	
Has Patient been previously treated for this condition? ☐ YES ☐ NO	
Date of Diagnosis:	
ICD-10 Codes: ☐ F11.2 Opioid dependence ☐ F11.20 Opioid dependence, uncomplicated ☐ F11.21 Opioid dependence, in remission ☐ F11.22 Opioid dependence with intoxication ☐ F11.23 Opioid dependence with withdrawal	
Is Patient Currently on Therapy: ☐ YES ☐ NO	
Date of Last Administration:	Next Scheduled Injection Date:

Right to Choose Pharmacy: By signing this form, I select Curant Health as my pharmacy. I understand that I have the right to choose the pharmacy from which I will receive medications and am not obligated to use Curant Health as my pharmacy. I also understand that I may discontinue using Curant Health at any time.

Release of Information & Consent to Ship Medications: I hereby authorize Curant Health to contact my prescribing provider to coordinate the delivery, receipt, and storage of my Sublocade prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. I understand that my signature below serves as the Patient Ship Authorization, which means the pharmacy will not contact me prior to shipment.

Patient Authorization: _____ **Date**: _____