

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____ Ht: _____ Wt: _____

Please Attach: ☐ Insurance cards ☐ History & Physical ☐ Most recent labs ☐ Medication list

☐ NKDA ☐ Allergies: _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ ZIP: _____

REQUIRED INFORMATION

☒ Tried and Failed Medications (please specify)

☒ Testing or labs

MEDICATION ORDERS

ICD-10 Diagnosis Codes: ☐ F11.20 Opioid dependence, uncomplicated ☐ F11.21 Opioid dependence, in remission
☐ F11.29 Opioid dependence, with unspecified opioid-induced disorder

☐ **Other :** _____

☐ **New to Therapy** ☐ **Continuation of Therapy:** Date of last dose (if applicable): _____

DOSING/FREQUENCY:

☒ BRIXADI should be injected slowly, into the subcutaneous tissue of the buttock, thigh, abdomen, or upper arm

Weekly : ☐ 8 mg ☐ 16 mg ☐ 24 mg ☐ 32 mg

Monthly : ☐ 64 mg ☐ 96 mg ☐ 128 mg

☐ Other: _____ ☐ Refills: _____

☒ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

Date