HOMETOWN PHARMACY
Specialty Care Program

SUBSTANCE ABUSE SPECIALTY CARE PROGRAM

Phone: **844-812-9397** • Fax: **855-414-4886**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: ______________________________
Address: ______________________________
City: ______________ State: ____ Zip: ________
Phone: ____________ Alt. Phone: ____________
Email: ______________________________
DOB: ________ Gender: ❍ M ❍ F Caregiver: ________
Height: ______ Weight: ______ Allergies: ________

2 PRESCRIBER INFORMATION:

Name: ______________________________
Address: ______________________________
City: ______________ State: ____ Zip: ________
Phone: ____________ Fax: ____________
NPI: ____________ DEA: ____________
Tax I.D.: ______________________________
Office Contact: ____________ Phone: ____________

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3 STATEMENT OF MEDICAL NECESSITY:

ICD-10: ______________________ ❑ Acute ❑ Chronic
Date of Diagnosis: ________ Contraindications: ❑ Yes ❑ No ________
Current opioid therapy: ________ Total morphine equivalents: ________
Current benzodiazepine use? ❑ Yes ❑ No
Medication: ______________

If Prior Authorization is Denied:
❑ Automatically Draft Appeal for Review
❑ Send Preferred Formulary Alternatives

Previous failed therapy:
Medications: ❑ Yes ❑ No
If yes please list: ______________________________
____
Physical Therapy: ❑ Yes ❑ No Date: ______________
Previous use of Naloxone? ❑ Yes ❑ No
CYP2D6 Metabolism: ❑ Rapid ❑ Normal ❑ Intermediate ❑ Poor
❑ Unknown Perform Testing: ❑ Yes ❑ No

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4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: ______________________________ Patient's Date of Birth: ______________

Medication	Dosage & Strength	Direction	QTY	Refills
❑ EVZIO®	❑ 2mg/0.4ml Autoinjector	❑ Administer contents of autoinjector (2mg) into the thigh as a single dose. Dose may be repeated every 2 to 3 minutes until emergency medical assistance becomes available	2	
❑ NARCAN® NS	❑ 4mg Nasal Spray	❑ Administer contents of 1 nasal spray (4mg) into nose as a single dose. Dose may be repeated every 2 to 3 minutes in alternating nostrils until emergency medical assistance becomes available	2	
❑ NALOXONE PFS	❑ 2mg/2ml Injector	❑ Administer contents of 1 syringe (2mg) into the muscle or under the skin as a single dose. Dose may be repeated every 2 to 3 minutes until emergency medical assistance becomes available	1	
❑ VIVITROL®	❑ 360mg Vial/Kit	❑ ______________________	1	11
❑ ______________	______________	______________________		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______________________ Date: ________ Signature: ______________________ Date: ________
Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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