REFERRAL FORM

www.speranzatherapeutics.com
Phone: 1-866-923-0710
Fax: 1-855-479-0964

Referral Type: ☐ Benefit Verification/Authorization ☐ Pharmacy Services

PATIENT

Patient Name:

Patient Address: | City: | State: | Zip:

Patient Phone: | Date of Birth: | Gender: ☐ Male ☐ Female

Ship to Patient at: ☐ Physician Office ☐ Rehab/Treatment Center

REHAB TREATMENT CENTER

Rehab/Treatment Center Name: | Rehab/Treatment Center Phone:

Rehab/Treatment Address: | City: | State: | Zip:

PRESCRIBER

Healthcare Professional Name: | NPI:

Practice Name:

Office Address: | City: | State: | Zip:

Office Contact: | Office Phone: | Office Fax:

INSURANCE - Please attach copies of patient's insurance card.

Insured's Name: | Relation to Patient:

Medicare: ☐ Yes ☐ No | If yes, Medicare #:

Plan Name: | Plan ID: | Policy/Group #:

Phone: | Fax:

ICD 10 CODE

F11.23 Opioid dependence with withdrawal

OTHER

PROCEDURE CODE

OTHER

PRESCRIPTION

Physician Orders:

Product: **S.T. Genesis** | Quantity: | Refills:

Instructions for use: Place as directed by clinician for reduction of opioid withdrawal symptoms for up to 120 hours.

Dispense as Written: | Signature:

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed ST Genesis based on my professional judgment of medical necessity. I authorize Speranza and its representatives and agents through the ST Genesis Reimbursement Program ("the "Program") to investigate insurance coverage and information and any other Program related services that I may request for the above name patient. I have a signed copy on file of my patient's current and completed HIPAA Authorization Form so that I may share patient health information with the Program. I authorize HUB to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. State-required statement: The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber Prescriber Signature: Prescriber must manually sign the appropriate section on how to dispense.

Prescriber Signature:_____ Date:_____ Prescriber's Email:_____