Brixadi® (buprenorphine) extended-release injection for subcutaneous use (CIII)

Optional BRIXADI Bridge Program

1 Patient Information

First Name:	Last Name:	DOB: MM / DD / YYYY	Gender at Birth: ☐ Male ☐ Female
Address:	City:	State:	ZIP Code:	Email:
Cell Phone:	Work/Home Phone:	Preferred Contact Method: ☐ Text ☐ Phone ☐ Email	

2 Prescriber Information

Prescriber Name:	Prescriber NPI #:	State License #:	License State:
Prescriber DEA #:	Supervising Physician Name (if appropriate):	Supervising Physician DEA #:	
Office Address:	City:		
State:	ZIP Code:	Phone:	Fax:
Office Contact Name:	Contact Email Address:	Office Contact Phone:	
Facility Name:	Practice NPI #:	Facility Type: ☐ Provider Office ☐ Outpatient Treatment Facility ☐ Other	

DEA Shipping Address (of prescriber, if different from above):

Shipping Location DEA # (if different from above):

NOTE: BRIXADI orders cannot be fulfilled unless the shipping address matches the registered address on file with the DEA.

3 BRIXADI Bridge Program (BBP) Attestation

BRIXADI Bridge Program Eligibility: Patients can receive BRIXADI at no cost while pursuing insurance coverage. Must have commercial or government insurance, a valid prescription for the BRIXADI Bridge Program, and a prior authorization, along with fulfillment logistics that will result in a delay of 5 days or greater. Prescriber must sign attestation.

Remember: Continue to complete all prior authorization requirements completely and accurately for the insurance company to complete review of patient eligibility for BRIXADI.

The BBP allows patients to receive up to a 4-week or 1-month supply of BRIXADI under the program.

The BRIXADI Bridge Program will end when one of the following occurs:

- The prior authorization is approved and the commercial prescription can begin
- The prior authorization is still pending at 28 days and bridge is terminated
- An appeal has been processed and the prior authorization is declined

BRIXADI Bridge Prescriber Attestation: I certify and attest to the following:

a. The patient is new to BRIXADI treatment or has begun treatment but has changed health insurance, requiring a new coverage determination, and a bridge is necessary while that determination is pending.

b. I have made an independent prescribing decision and have no obligation to continue prescribing BRIXADI.

c. The product furnished through the BBP will be used only for the patient under the BBP and will not be sold or billed to third-party payers.

d. Neither I nor the patient has any obligation to continue using BRIXADI or to purchase commercial product from the specialty pharmacy.

e. I am sending the BBP form and associated prescription to _____ specialty pharmacy and will not send a duplicate prescription to another specialty pharmacy.

Braeburn reserves the right to restrict access to the BRIXADI Bridge Program (BBP) upon failure to comply with the attestation.

Sign BBP Attestation Prescriber Signature Required* Date: MM / DD / YYYY

NOTE: The following prescription part of this form must be completed OR this form must be accompanied by a unique prescription. When required by law, send electronic prescription or on official state prescription blank clearly marked as BRIDGE.

Primary Diagnosis (ICD-10 Code):

Drug Name, Strength, and Dosage Form:

Directions/Sig:

Date: MM / DD / YYYY

Quantity (Numeric & Written):

Refills (Numeric & Written):

Dispense As Written Prescriber Signature Required* Date: MM / DD / YYYY

Substitutions Allowed Prescriber Signature Required* Date: MM / DD / YYYY

*Signature stamps not acceptable.

Please see the BRIXADI Full Prescribing Information, including Boxed Warning, at BRIXADIhcp.com or accompanying this document.

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