

OPIOID ANTAGONIST PRESCRIPTION SHEET

Patient Name _____ DOB _____

Address _____ Date _____

A. Intranasal naloxone 4 mg/0.1 ml

Sig: Spray one device into nostril upon signs of opioid overdose. Call 911. Repeat with second device in the other nostril if no response within 2-3 minutes.

Dispense # _____

B. Intranasal naloxone 8 mg/0.1 ml

Sig: Spray one device into nostril upon signs of opioid overdose. Call 911. Repeat with second device in the other nostril if no response within 2-3 minutes.

Dispense # _____

C. Intranasal nalmefene 2.7 mg/0.1 ml

Sig: Spray one device into nostril upon signs of opioid overdose. Call 911. Repeat with second device in the other nostril if no response within 2-3 minutes.

Dispense # _____

Pharmacist Signature _____ Refills _____

BRAND MEDICALLY NECESSARY Yes / No