Fax Referral To:
814-283-2211

www.vsprx.com

Phone: 855-265-8008

VALUE SPECIALTY PHARMACY

Long Acting Injectable Antipsychotic Enrollment Form

Date: _____ **Needs by Date:** _____

Ship to:
- ☐ **Patient**
- ☐ **Office**
- ☐ **Other:**

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Prescription Card: __ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: __ ID#: _____ Name of Insurer: _____ Phone: _____
Secondary Insurance: __ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-10:

_____
_____
_____
_____

• Date of Diagnosis: _____

Additional Clinical Information: Therapy: ☐ New ☐ Reauthorization ☐ Restart

• Weight: _____ kg/lbs • Height: _____ in/cm
• Allergies: _____
• Lab Data: _____
• Concomitant Medications: _____
• Additional Comments: _____

• Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No • If Yes, Date: _____

• Specialty Pharmacy to coordinate injection training/home health nursing. ☐ Yes ☐ No *Agency of Choice: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS		QUANTITY	REFILLS
☐ **Abilify Maintena** ☐ **Abilify Maintena DCS**	☐ **300mg** ☐ **400mg**	**Prescriber to inject contents of one syringe (400mg) intramuscularly once every 28 days**		**#1**	
☐ **Aristada**	☐ **441mg** ☐ **662mg** ☐ **882mg**	**Prescriber to inject contents of one syringe intramuscularly**	☐ **every 28 days** ☐ **every 42 days**	**#1**	
☐ **Invega Sustenna**	☐ **39mg** ☐ **78mg** ☐ **117mg** ☐ **156mg** ☐ **234mg**	**Prescriber to inject contents of one syringe intramuscularly once every 28 days**		**#1**	
☐ **Invega Trinza**	☐ **273mg** ☐ **410mg** ☐ **546mg** ☐ **819mg**	**Prescriber to inject contents of one syringe intramuscularly once every 3 months**		**#1**	
☐ **Risperdal Consta**	☐ **25mg** ☐ **37.5mg** ☐ **50mg**	**Prescriber to inject contents of one syringe intramuscularly once every 14 days**		**#2**	

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

Physician Signature _____ Date _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right ☐