



# Injectable Antipsychotic Enrollment Form

Patient Data

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs \_\_\_\_\_ kg \_\_\_\_\_  
 SSN #: XXX-XX-\_\_\_\_ Known Allergies: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Alternate Caregiver Name: \_\_\_\_\_ Phone of Caregiver: \_\_\_\_\_

Ins. Data

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
 Policy: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy: \_\_\_\_\_ Group#: \_\_\_\_\_

Clinical Information

*Please attach clinical notes, therapy history, and medication list to expedite the prior authorization*

Diagnosis: \_\_\_\_\_ ICD 10 code: \_\_\_\_\_  
 Secondary Diagnosis: \_\_\_\_\_ ICD 10 code: \_\_\_\_\_  
 Has patient had prior treatment for this diagnosis?  Yes  No Scheduled Injection Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date(s) of previous therapy and medication: \_\_\_\_\_  
 Injection to be administered by prescriber's office  Value Specialty Pharmacy to coordinate injection services

Prescription

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Abilify Maintena®	<input type="checkbox"/> 300mg DCS <input type="checkbox"/> 400mg DCS	Prescriber to inject contents of one syringe intramuscularly once every 28 days	#1	
<input type="checkbox"/> Aristada®	<input type="checkbox"/> 441mg <input type="checkbox"/> 662mg <input type="checkbox"/> 882mg <input type="checkbox"/> 1064 mg	Prescriber to inject contents of one syringe intramuscularly <input type="checkbox"/> every 28 days <input type="checkbox"/> every 42 days <input type="checkbox"/> every 56 days	#1	
<input type="checkbox"/> Aristada Initio®	<input type="checkbox"/> 675mg	Prescriber to inject 675mg intramuscularly once then begin maintenance within 10 days	#1	0
<input type="checkbox"/> Fluphenazine Decanoate	<input type="checkbox"/> 125mg/5ml vial	Prescriber to inject _____mg intramuscularly once every _____weeks	Quantity Sufficient for 30 days	
<input type="checkbox"/> Haloperidol Decanoate	<input type="checkbox"/> 100mg/ml vial <input type="checkbox"/> 50mg/ml vial	Prescriber to inject _____mg intramuscularly once every _____weeks	Quantity Sufficient for 30 days	
<input type="checkbox"/> Invega Sustenna®	<input type="checkbox"/> 39mg <input type="checkbox"/> 78mg <input type="checkbox"/> 117mg <input type="checkbox"/> 156mg <input type="checkbox"/> 234mg	<input type="checkbox"/> Loading Dose: Prescriber to inject 234mg intramuscularly on day 1, then inject 156mg intramuscularly on day 8, then begin maintenance	234mg - #1 156mg - #1	0
		Prescriber to inject _____mg intramuscularly once every 28 days	#1	
<input type="checkbox"/> Invega Trinza®	<input type="checkbox"/> 273mg <input type="checkbox"/> 410mg <input type="checkbox"/> 546mg <input type="checkbox"/> 819mg	Prescriber to inject contents of one syringe intramuscularly once every 3 months	#1	
<input type="checkbox"/> Invega Hafyera™	<input type="checkbox"/> 1,092mg <input type="checkbox"/> 1,560mg	Prescriber to inject contents of one syringe intramuscularly once every 6 months	#1	
<input type="checkbox"/> Perseris™	<input type="checkbox"/> 90mg <input type="checkbox"/> 120mg	Prescriber to inject contents of one syringe subcutaneously once monthly	#1	
<input type="checkbox"/> Risperdal Consta®	<input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg <input type="checkbox"/> 37.5mg <input type="checkbox"/> 50mg	Prescriber to inject contents of one syringe intramuscularly once every 14 days	#2	
<input type="checkbox"/> Zyprexa® Relprevv™ <i>REMS program required</i>	<input type="checkbox"/> 210mg vial kit <input type="checkbox"/> 300mg vial kit <input type="checkbox"/> 405mg vial kit	Prescriber to inject contents of one syringe intramuscularly <input type="checkbox"/> every 14 days <input type="checkbox"/> every 28 days		

Is patient new to this therapy:  YES  NO | Ship to:  Patient  Office  Other

Prescriber Data

Prescriber Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Key Contact#: \_\_\_\_\_

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 process.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.