Injectable Antipsychotic A-N 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: ______________________ Patient Email: ______________________

Ins. Data

Primary Insurance: ______________________ Secondary Insurance: ______________________

Policy: ______________________ Group#: __________ Policy: ______________________ Group#: __________

❑ ***Patient has commercial insurance and authorizes pharmacy to apply for manufacturer copay card. Email must be provided above.***

Clinical Info

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 treament 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
❑ Abilify Asimtufii®	❑ 720mg ❑ 960mg	Prescriber to inject contents of one syringe intramuscularly once every 56 days	#1	
❑ Abilify Maintena®	❑ 300mg DCS ❑ 400mg DCS	Prescriber to inject contents of one syringe intramuscularly once every 28 days	#1	
❑ Aristada®	❑ 441mg ❑ 662mg ❑ 882mg ❑ 1064 mg	Prescriber to inject contents of one syringe intramuscularly — ❑ every 28 days ❑ every 42 days ❑ every 56 days	#1	
❑ Aristada Initio®	❑ 675mg	Prescriber to inject 675mg intramuscularly once then begin maintenance within 10 days	#1	0
❑ Fluphenazine Decanoate	❑ 125mg/5ml vial	Prescriber to inject ___________mg intramuscularly once every _________weeks	Quantity Sufficient for 30 days	
❑ Haloperidol Decanoate	❑ 100mg/ml vial ❑ 50mg/ml vial	Prescriber to inject ___________mg intramuscularly once every _________weeks	Quantity Sufficient for 30 days	
❑ Invega Sustenna®	❑ 39mg ❑ 78mg ❑ 117mg ❑ 156mg ❑ 234mg	❑ 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	
❑ Invega Trinza®	❑ 273mg ❑ 410mg ❑ 546mg ❑ 819mg	Prescriber to inject contents of one syringe intramuscularly once every 3 months	#1	
❑ Invega Hafyera™	❑ 1,092mg ❑ 1,560mg	Prescriber to inject contents of one syringe intramuscularly once every 6 months	#1	

Is patient new to this therapy: ❑ YES ❑ NO | **Ship to:** ❑ 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.