Injectable Antipsychotic P-Z Enrollment Form

VALUE SPECIALTY PHARMACY

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name/Phone: _____

Sex: ❑ Male ❑ Female Height: _____ Weight: _____ lbs kg
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Patient Email: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
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
❑ Perseris™	❑ 90mg ❑ 120mg	Prescriber to inject contents of one syringe subcutaneously once monthly	#1	
❑ Risperdal Consta®	❑ 12.5mg ❑ 25mg ❑ 37.5mg ❑ 50mg	Prescriber to inject contents of one syringe intramuscularly once every 14 days	#2	
❑ Uzedy™	❑ 50mg ❑ 75mg ❑ 100mg ❑ 125mg	Prescriber to inject contents of one syringe subcutaneously once monthly	#1	
	❑ 100mg ❑ 150mg ❑ 200mg ❑ 250mg	Prescriber to inject contents of one syringe subcutaneously once every 2 months	#1	
❑ Zyprexa® Relprevv™ *REMS program required*	❑ 210mg vial kit ❑ 300mg vial kit ❑ 405mg vial kit	Prescriber to inject contents of one syringe intramuscularly ❑ every 14 days ❑ every 28 days		

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

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____
Phone: _____ Fax: _____
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.