

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY:

ICD-10: _____ Acute Chronic
 Date of Diagnosis: _____ Contraindications: No Yes _____
Diagnosis Procedure(s) or Laboratory Test(s):
 Test/Procedure: _____ Date Performed: _____ Results: _____
 1. _____
 2. _____
 3. _____

| Prior Failed Treatments: | Length of Treatment: |
|--------------------------|----------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING:

To Be Administered by Pharmacist (State of Missouri Only) Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient DOB: _____ **Must Provide All Prescription Information**

| Medication | Dosage & Strength | Direction | QTY | Refills |
|--|--|--------------------------------|-----|---------|
| <input type="checkbox"/> ABILIFY MAINTENA® | <input type="checkbox"/> 300mg Lyophilized Powder <input type="checkbox"/> 400mg Lyophilized Powder | <input type="checkbox"/> _____ | | |
| <input type="checkbox"/> ARISTADA® | <input type="checkbox"/> 441mg Prefilled Syringe <input type="checkbox"/> 662mg Prefilled Syringe <input type="checkbox"/> 882mg Prefilled Syringe <input type="checkbox"/> 1064mg Prefilled Syringe | <input type="checkbox"/> _____ | | |
| <input type="checkbox"/> EVZIO® | <input type="checkbox"/> 2mg/0.4ml Autoinjector | <input type="checkbox"/> _____ | | |
| <input type="checkbox"/> INVEGA SUSTENNA® | <input type="checkbox"/> 39mg Prefilled Syringe <input type="checkbox"/> 78mg Prefilled Syringe <input type="checkbox"/> 117mg Prefilled Syringe <input type="checkbox"/> 156mg Prefilled Syringe <input type="checkbox"/> 234mg Prefilled Syringe | <input type="checkbox"/> _____ | | |
| <input type="checkbox"/> RISPERDAL CONSTA® | <input type="checkbox"/> 12.5mg Vial/Kit <input type="checkbox"/> 25mg Vial/Kit <input type="checkbox"/> 37.5mg Vial/Kit <input type="checkbox"/> 50mg Vial/Kit | <input type="checkbox"/> _____ | | |
| <input type="checkbox"/> VIVITROL® | <input type="checkbox"/> 380mg Vial/Kit | <input type="checkbox"/> _____ | 1 | 11 |
| <input type="checkbox"/> VRAYLAR® | <input type="checkbox"/> 1.5mg Capsules <input type="checkbox"/> 3mg Capsules <input type="checkbox"/> 4.5mg Capsules <input type="checkbox"/> 6mg Capsules | <input type="checkbox"/> _____ | | |
| <input type="checkbox"/> ZYPREXA® RELPREV™ | <input type="checkbox"/> 210mg Vial <input type="checkbox"/> 300mg Vial <input type="checkbox"/> 405mg Vial | <input type="checkbox"/> _____ | | |
| <input type="checkbox"/> _____ | | | | |

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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