



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: _____

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 Prescriber to inject _____mg intramuscularly once every 28 days	234mg - #1 156mg - #1	0
<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: _____ Preferred Method: Phone Fax Email
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Email: _____

My signature below authorizes Restore Rx, Inc. 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 Restore Rx, Inc. 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.