Atypical Antipsychotic Enrollment Form

InfuCare Rx

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PATIENT INFORMATION			PRESCRIBER INFORMATION		
Name:			Prescribing Practitioner:		NPI:
Address:			Address:		
City:	State/Zip:		City:		State/Zip:
Telephone:	DOB:	M ☐ F ☐	Office:		DEA:
Language Preference:	Wt:	Ht:	Contact:	Phone:	Fax:

PRIMARY INSURANCE INFORMATION			
Member Name:	M ☐ F ☐	DOB:	
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:	Please attach a copy of the front and back of the patient's insurance card, if available.*****	

PLEASE FAX COPY OF: ☐ **PRESCRIPTION FRONT & BACK** ☐ **CLINICAL NOTES** ☐ **MEDICAL CARD FRONT & BACK**

PRESCRIPTION

New ☐ Refill ☐ | Ship by: | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

Drug	Strength	Directions	Quantity	Refills
Abilify Maintena®	☐ Kit ☐ Syringe	☐ Administer 160mg IM every month ☐ Administer 200mg IM every month ☐ Administer 300mg IM every month ☐ Administer 400mg IM every month	☐ 1 unit ☐ 3 units	
Aristrada Initio ® (aripiprazole lauroxil)	☐ WITH oral aripiprazole	☐ Administer 160mg IM every month ☐ Administer 200mg IM every month	☐ 1 unit ☐ 1 tablet	
Aristrada® (aripiprazole lauroxil)		☐ Administer 441mg IM every month ☐ Administer 662mg IM every month ☐ Administer 882mg IM every 6 weeks ☐ Administer 1064mg IM every 2 months	☐ 1 unit ☐ 3 units	
Invega Sustenna® (paliperidone)		☐ **Loading Dose (Day 1):** Administer 234mg IM (deltoid) on treatment day 1 ☐ **Follow Up Dose (Day 8):** Administer 156mg IM (deltoid) on treatment day 8 ☐ **Maintenance Dose (Day 8):** ☐ Administer 39mg/0.25mL IM (deltoid/VG) every 4 weeks ☐ Administer 78mg/0.5mL IM (deltoid/VG) every 4 weeks ☐ Administer 117mg/0.75mL IM (deltoid/VG) every 4 weeks ☐ Administer 156mg/1mL IM (deltoid/VG) every 4 weeks ☐ Administer 234mg/1.5mL IM (deltoid/VG) every 4 weeks	☐ 1 unit ☐ 3 units	
Invega Trinza® (paliperidone)		☐ Administer 12.5mg IM every 2 weeks ☐ Administer 25mg IM every 2 weeks ☐ Administer 37.5mg IM every 2 weeks ☐ Administer 50mg IM every 2 weeks	☐ 1 unit ☐ 3 units	
Resperdal Consta® (risperidone)		☐ Administer 12.5mg IM every 2 weeks ☐ Administer 25mg IM every 2 weeks ☐ Administer 37.5mg IM every 2 weeks ☐ Administer 50mg IM every 2 weeks	☐ 1 unit ☐ 3 units	

ICD10 & Diagnosis:

Allergies:

Treatment ☐ New to Therapy ☐ New to Therapy

Date of Last Administration: _____

For Invega only: Day 1 dose _____ mg Date: _____

Day 8 dose _____ mg Date: _____

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: | **Date:**