InfuCare Rx

Atypical Antipsychotic Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: ____________ Ship To: ☐ Patient ☐ MD Office ☐ Other: ____________

PATIENT INFORMATION

Patient Name: ____________
Address: ____________
City, State, Zip: ____________
Home Phone: ____________
Cell Phone: ____________
Date of Birth: ____________ Gender: ____________
Emergency Contact: ____________ Phone: ____________

PRESCRIBER INFORMATION

Prescriber Name: ____________
Address: ____________
City, State, Zip: ____________
Phone: ____________
Fax: ____________
DEA #: ____________ NPI #: ____________
Contact Person: ____________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ____________ ID: ____________ Group: ____________
Secondary Insurance: ____________ ID: ____________ Group: ____________
Prescription Card: ____________ ID: ____________ BIN: ____________ PCN: ____________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ F99 Unspecified Mental Disorder
☐ Other: ____________

For Invega only:
Day 1 dose ____________ Date: ____________
Day 8 dose ____________ Date: ____________

Weight: ______ ☐ kg ☐ lbs Height: ______ ☐ cm ☐ in %BSA: ______
Allergies: ____________ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other: ____________
☐ New to Therapy Date of Last Administration: ____________

PRESCRIPTION INFORMATION

Medication:	Dose/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 per 0.25mL IM (deltoid per VG) every 4 weeks ☐ Administer 78mg per 0.5mL IM (deltoid per VG) every 4 weeks ☐ Administer 117mg per 0.75mL IM (deltoid per VG) every 4 weeks ☐ Administer 156mg per 1mL IM (deltoid per VG) every 4 weeks ☐ Administer 234mg per 1.5mL IM (deltoid per 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	
☐ Other:				

ADDITIONAL COMMENTS

Prescriber Signature: ____________ Date: ____________

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by faxing back to the originator.