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:** ______________

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