Injectable Antipsychotic Enrollment Form

RESTORE Rx SPECIALTY PHARMACY

Date: _____

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 treament for this diagnosis? ☐ Yes ☐ No Scheduled Injection Date: _____/_____/_____
Date(s) of previous therapy and medication: _____
☐ Injection to be administered by prescriber's office ☐ Restore Rx to coordinate injection services

Prescription

Medication	Strength	Directions	Quantity	Refills
☐ Abilify Maintena®	☐ 300mg DCS ☐ 400mg DCS	Prescriber to inject contents of one syringe intramuscularly once every 28 days	#1	
☐ Aristada®	☐ 441mg ☐ 662mg ☐ 882mg ☐ 1064 mg	Prescriber to inject contents of one syringe intramuscularly ☐ every 28 days ☐ every 42 days ☐ every 56 days	#1	
☐ Aristada Initio®	☐ 675mg	Prescriber to inject 675mg intramuscularly once then begin maintenance within 10 days	#1	0
☐ Fluphenazine Decanoate	☐ 125mg/5ml vial	Prescriber to inject _____mg intramuscularly once every _____weeks	Quantity Sufficient for 30 days	
☐ Haloperidol Decanoate	☐ 100mg/ml vial ☐ 50mg/ml vial	Prescriber to inject _____mg intramuscularly once every _____weeks	Quantity Sufficient for 30 days	
☐ Invega Sustenna®	☐ 39mg ☐ 78mg ☐ 117mg ☐ 156mg ☐ 234mg	☐ Loading Dose: Prescriber to inject 234mg intramuscularly on day 1, then inject 156mg intramuscularly on day 8, then begin maintenance	234mg - #1 156mg - #1	0
		Prescriber to inject _____mg intramuscularly once every 28 days	#1	
☐ Invega Trinza®	☐ 273mg ☐ 410mg ☐ 546mg ☐ 819mg	Prescriber to inject contents of one syringe intramuscularly once every 3 months	#1	
☐ Perseris™	☐ 90mg ☐ 120mg	Prescriber to inject contents of one syringe subcutaneously once monthly	#1	
☐ Risperdal Consta®	☐ 12.5mg ☐ 25mg ☐ 37.5mg ☐ 50mg	Prescriber to inject contents of one syringe intramuscularly once every 14 days	#2	
☐ Zyprexa® Relprevv™ *REMS program required*	☐ 210mg vial kit ☐ 300mg vial kit ☐ 405mg vial kit	Prescriber to inject contents of one syringe intramuscularly ☐ every 14 days ☐ 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. ☐