

New to Therapy
 Current Therapy

Patient Information

Patient Name: _____
Date of Birth: _____ Sex: M or F Caregiver: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Policy holder Employer: _____
Relationship to Patient: _____
ID# _____ Group# _____
RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____
DEA# _____ NPI# _____
License#: _____ Medicaid UPIN#: _____
Physician Specialty: _____
Date Shipment Needed: _____
Ship to: Patient Prescriber Other: _____
Shipment Address: _____ Attn: _____
City: _____ State: _____ Zip: _____
If shipped to the prescriber's office, Prescriber accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis: F84.0 Autistic Disorder F30.____ Mood Disorder
 F20.____ Schizophrenic disorder ____ . ____ Description: _____
Date of Diagnosis or Years with Disease: _____
Patients Allergies: _____
Latex allergy: Yes No Patient Weight: _____ Patient Height: _____
Medical History -Please attach all lab/test results/treatment plans
Comorbidities: _____
Previous and Current Medication Use:

 Current Failed Intolerant Other: _____ Dates used: _____

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 Current Failed Intolerant Other: _____ Dates used: _____

Expected First Dose Date: _____

Abilify Maintena™ (aripiprazole extended release injectable suspension)
 300mg 400mg To be injected IM every month by prescriber as directed.

Aristada™ (aripiprazole extended release injectable suspension)
 441mg 662mg 882mg To be injected IM every month by prescriber as directed.
 882mg To be injected IM every 6 weeks by prescriber as directed.
 1,064mg To be injected IM every 2 months by prescriber as directed.
 675 mg (Initio) Single dose only to be injected IM as directed

Invega Hafyera™ (six-month paliperidone palmitate)
 1,092 mg 1,560 mg Gluteal IM injection once every 6 months by prescriber as directed

Invega Sustenna® (paliperidone palmitate extended –release injectable suspension)
 39mg 78mg 117mg 156mg 234mg
To be injected IM every month as directed.
 Initiation dose: _____mg IM on day 1, then _____mg IM one week later

Invega Trinza™ (three-month paliperidone palmitate)
 273mg 410mg 546mg 819mg
To be injected IM every 3 months by prescriber as directed.

Risperdal Consta® (risperidone IM injection) OR Perseris (risperidone SC injection)
 12.5mg 25mg 37.5mg 50mg 90mg 120mg
To be injected IM every 2 weeks as directed. To be injected SC once monthly

Zyprexa® Relprevv™ (olanzapine extended-release injectable suspension)
 210mg 300mg To be injected IM every 2 weeks by prescriber as directed.
 405mg To be injected IM every 4 weeks by prescriber as directed.

Write DAW if Required

Quantity Prescribed _____ Refills Authorized: 0 1 2 3 6 11 Other: _____
Signature: X _____ Date: ____/____/____

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.
Updated September 2023