ANTIPSYCHOTIC MEDICATIONS REFERRAL FORM

BIOMATRIX SPRX **TEL:** 855-359-9679 **FAX:** 610-545-6030

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____
☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____
☐ _____ #_____ ☐ _____ #_____ ☐ _____ #_____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Code: _____ Diagnosis: _____

Does the patient have a history of noncompliance with a prior oral anti-psychotic regimen? ☐ Yes ☐ No ☐ N/A
If yes, please attach documentationof what adherence measures were done.

Has the patient in the past received oral Risperdal or oral Invega without any significant side effects? ☐ Yes ☐ No

Does the patient have renal and/or hepatic impairment? ☐ Yes ☐ No

What is the requested duration of therapy? ☐ < 6 months ☐ > 6 months

Delivery date needed _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **ABILIFY MAINTENA**
Strength: ☐ 300 mg ☐ 400 mg
☐ SIG: IM 4 weeks
QTY: _____ Refills: _____
☐ Other:_____
QTY: _____ Refills: _____

☐ **ARISTADA**
Strength: ☐ 441 mg ☐ 662 mg ☐ 882 mg ☐ 1064 mg
☐ SIG: IM _____ weeks
QTY: _____ Refills: _____
☐ Other:_____
QTY: _____ Refills: _____

☐ **INVEGA SUSTENNA**
Strength: ☐ 39 mg ☐ 78 mg ☐ 117 mg
☐ 156 mg ☐ 234 mg
IM initiation day 1 dose
☐ SIG: Inject ____ mg IM
QTY: _____ Refills: _____
IM initiation day 8 dose
☐ SIG: Inject ____ mg IM
QTY: _____ Refills: _____
IM maintenance monthly dose
☐ SIG: Inject ____ mg IM
QTY: _____ Refills: _____
☐ Other:_____
QTY: _____ Refills: _____

☐ **INVEGA TRINZA** *use only after stabilized on Invega Sustenna*
Strength: _____ mg
☐ SIG: IM every 3 months
QTY: _____ Refills: _____
☐ Other:_____
QTY: _____ Refills: _____

☐ **RISPERDAL CONSTA**
Strength: ☐ 12.5 mg ☐ 25 mg ☐ 37.5 mg ☐ 50 mg
☐ Sig: IM Biweekly
QTY: _____ Refills: _____
☐ Other:_____
QTY: _____ Refills: _____

☐ **ZYPREXA RELPREVV**
Strength: ☐ 210 mg/vial ☐ 300 mg/vial ☐ 405 mg/vial
☐ SIG:_____
QTY: _____ Refills: _____

☐ **OTHER** _____
SIG _____
QTY: _____ Refills: _____

☐ **OTHER** _____
SIG _____
QTY: _____ Refills: _____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature _____ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date**_____

Prescriber's Email_____