LONG-ACTING INJECTABLE ATYPICAL ANTIPSYCHOTIC

210 Rock Rd | Glen Rock, NJ 07452
866-888-3200 TEL: 201-444-3200 FAX: 201-444-5792

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

June 2016

Patient Name ____ First Name ____ Middle Name ____ Last Name ____ DOB ________ Weight ________ ☐ Male ☐ Female

Street Address ________________________ Apt # ______ City ____________ State ________ Zip ________

Daytime Tel __________ Evening Tel ____________ Cell ____________ Email ______________________

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed ____________

Diagnosis ________________________________ ICD-10 Code ______________________

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# ________________

Prescriber's Name ________________________________ Office Contact ______________________

Street Address ________________________ Suite # ______ City ________________ State ________ Zip ________

Tel ____________ Fax ________________ Email ______________________________

License# ______________ NPI# ________________ UPIN# ________________ DEA# ____________

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

ABILIFY MAINTENA* ☐ 300 mg syringe ☐ 400 mg syringe
SIG: Inject _______ mg IM once monthly
QTY _______ Refills _______
**Dose adjust based on concomitant therapy*

RISPERDAL CONSTA
☐ 12.5 mg kit ☐ 25mg kit ☐ 37.5 mg kit ☐ 50 mg kit
SIG: Inject _______ mg IM every 2 weeks
QTY _______ Refills _______

PRISTIQ ☐ 25mg ☐ 50mg ☐ 100mg
SIG: Take _______ mg by mouth once daily
Other: ______________________ QTY _______ Refills _______

LATUDA ☐ 20mg ☐ 40mg ☐ 60mg ☐ 80mg ☐ 120mg
Take _______ mg by mouth once daily
Other: ______________________ QTY _______ Refills _______

INVEGA SUSTENNA SYRINGE
Initial Dosage: ☐ Inject 234 mg IM on treatment day 1, then 156 mg IM 1 week later.
Please specify quantity of each for starter dose:
______ 156 mg/mL ______ 234 mg/mL
Maintenance: ☐ Inject _______mg IM every month
QTY for maintenance: ______ 39 mg/0.25mL ______ 78 mg/0.5mL
______ 117 mg/ 0.75mL ______ 156 mg/mL ______ 234 mg/mL
Refills _______

ZYPREXA RELPREVV KIT
Initial dosage: ☐ Inject ______ mg IM every ______ weeks for ______ dose(s)
Please specify quantity for starter dose:
______ 210mg kit ______ 300mg kit ______ 405mg kit
Maintenance: ☐ Inject ______ mg IM every ______ weeks
QTY for maintenance dose: ______ 210mg kit ______ 300mg kit ______ 405mg kit
Refills ______

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ______________________________ **Date** ____________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains information that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Glen Rock Medical Pharmacy** at **201-444-5792** Visit us at **WWW.GLENROCKMEDICALPHARMACY.COM** for online fillable forms.

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NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS USING LONG-ACTING INJECTABLE ATYPICAL ANTIPSYCHOTICS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc…)
- ☐ Medication list and allergies
- ☐ Insurance information with RX insurance. Please include copy of card
  If the only card included is a medical card, please include local pharmacy information
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills
- ☐ MD signature and date on referral form
- ☐ Previous treatment
- ☐ Clinical notes

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

Has the patient taken the appropriate oral antipsychotic 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

Fax the requested documentation to (201) 444-5792
Toll Free: 1-866-888-3200 Direct Phone: (201) 444-3200
GlenRockMedicalPharmacy.com

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