

FEB 2018

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** _____

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