Mental Health Injectable Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

MHIRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis: _____
ICD10: _____

Please list previously tried/failed therapies & dates

Immunization History
☐ Influenza: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐**Abilify Maintena®** (aripiprazole, extended-release injectable suspension)	☐ 300 mg ☐ 400 mg	☐ Inject IM one time every month ☐ Other: _____		
☐**Aristada Initio™** (aripiprazole lauroxil, extended-release injectable suspension)	☐ 675 mg	☐ Administer one 675 mg injection IM and one 30 mg oral aripiprazole dose in conjunction with the first Aristada injection		
☐**Aristada®** (aripiprazole lauroxil, extended-release injectable suspension) *When initiating Aristada, administer with oral aripiprazole with or without Aristada Initio (see package labeling for details)	☐ 441 mg ☐ 662 mg ☐ 882 mg	☐ Inject IM one time every month		
	☐ 882 mg	☐ Inject IM one time every 6 weeks		
	☐ 1064 mg	☐ Inject IM one time every 2 months		
☐**Invega Sustenna®** (paliperidone palmitate, extended-release injectable suspension)	☐ 39 mg ☐ 78 mg ☐ 117 mg ☐ 156 mg ☐ 234 mg	**Initial:** ☐ Inject 234 mg IM on day 1 followed by 156 mg on day 8, then maintenance dose **Maintenance:** ☐ Inject IM one time every month		
☐**Invega Trinza®** (paliperidone palmitate, extended-release injectable suspension)	☐ 273 mg ☐ 410 mg ☐ 546 mg ☐ 819 mg	☐ Inject IM one time every 3 months **For use after adequate treatment with Invega Sustenna for 4 months*		
☐ **Perseris™** (risperidone, extended-release injectable suspension)	☐ 90 mg ☐ 120 mg	☐ Inject subcutaneously once every month		
☐**Risperdal® Consta®** (risperidone, long-acting injection)	☐ 12.5 mg vial kit ☐ 25 mg vial kit ☐ 37.5 mg vial kit ☐ 50 mg vial kit	☐ Inject IM one time every 2 weeks *When initiating Risperdal Consta, oral risperidone (or another antipsychotic) should be given with the first injection and continued for 3 weeks		
☐**Zyprexa® Relprevv™** (olanzapine, extended-release injectable suspension)	☐ 210 mg vial kit	☐ Inject IM one time every 2 weeks ☐ Other: _____		
	☐ 300 mg vial kit	☐ Inject IM one time every 2 weeks ☐ Inject IM one time every 4 weeks		
	☐ 405 mg vial kit	☐ Inject IM one time every 4 weeks		

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

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