LONG ACTING ANTI-PSYCHOTIC MEDICATION **FORM**

Connection • Care • Community

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

Patient Information

Please complete the following or send patient demographic sheet

Patient Name ______________________

Address ______________________

Address 2 ______________________

City ______________ State ______ Zip ______

Home Phone ______________ Alternate Phone ______________

DOB ______________ Last Four of SS# ______ Gender ◯ M ◯ F

Language Preference: ◯ English ◯ Spanish ◯ Other ______________

Prescriber Information

Prescriber's Name ______________________

DEA ______________________

NPI ______________________

Group/Hospital ______________________

Address ______________________

City ______________ State ______ Zip ______

Phone ______________ Fax ______________

Contact Person ______________ Phone ______________

Insurance Information: Fill out entirely or fax a copy of patient's insurance card including both sides.

Prescription Card:	Name of Insurer ______	ID# ______	BIN ______	PCN ______	Group ______
Primary Insurance:	Subscriber ______	ID# ______	Name of Insurer ______		Phone ______
Secondary Insurance:	Subscriber ______	ID# ______	Name of Insurer ______		Phone ______

Medical Information: Section must be completed to process prescription. (Attach separate sheet as needed)

Diagnosis - Please include diagnosis name with ICD-10 code

Diagnosis	**ICD-10 Code**

Additional Information | **Therapy:** ◯ **New** ◯ **Reauthorization** ◯ **Restart**

Weight ______________ kg/lbs Height ______________ cm/in

Allergies ______________________

Lab Data ______________________

Prior Therapies ______________________

Concomitant Medications ______________________

Additional Comments ______________________

Injection Training Required: ◯ Yes ◯ No

Prescription Information

Drugs	**Dose/Strength**	**Direction**	**Quantity**	**Refills**
Abilify Maintena®	◯ 300 mg syringe ◯ 400 mg syringe	Inject _____ mg IM once monthly		
Risperdal Consta®	◯ 12.5 mg kit ◯ 25 mg kit ◯ 37.5 mg kit ◯ 50 mg kit	Inject _____ mg IM every 2 weeks		
Invega Sustenna® Syringe	**Initial:** ◯ 156 mg/mL ◯ 234 mg/mL **Maintenance:** ◯ 39 mg/0.25mL ◯ 78 mg/0.5mL ◯ 117 mg/ 0.75mL ◯ 156 mg/mL ◯ 234 mg/mL	**Initial:** Inject 234 mg IM on treatment day 1, then 156 mg IM 1 week later. **Maintenance:** Inject _____mg IM every month		
Zyprexa Relprevv® Kit	**Initial:** ◯ 210mg kit ◯ 300mg kit ◯ 405mg kit **Maintenance:** ◯ 210mg kit ◯ 300mg kit ◯ 405mg kit	Initial: Inject ____ mg IM every ____ weeks for ____ dose(s) Maintenance: Inject ____ mg IM every ____ weeks		
Invega Trinza®	◯ 273mg ◯ 410mg ◯ 546mg ◯ 819mg	◯ Inject IM every 3 months		
Aristada®	◯ 441 mg 662 ◯ 882 mg ◯ 1064 mg	◯ Inject IM (deltoid) every month ◯ Inject IM (gluteal) every month or 6 weeks ◯ Inject IM (gluteal) every 2 months		
Rexulti®	◯ 0.25 ◯ 0.5mg ◯ 1mg ◯ 2mg ◯ 3mg ◯ 4mg	◯ Take one tablet by mouth daily with or without food		

Patient Authorization: I authorize this pharmacy to enroll me in the manufacturer's patient support program checked above to receive services such as, but not limited to, injection training. I further authorize this pharmacy to share minimum necessary information about my health condition and treatment to the manufacturer's program to provide disease state education materials, delivery of products and services offered by the program, and aggregated de-identified data for market analysis. I understand that may revoke this authorization at any time by contacting this pharmacy. I as I understand that I may refuse to sign this authorization and I will be eligible for treatment by this pharmacy.

Patient's Signature ______________________ ***Date*** ______

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature ______________________

PRODUCT SUBSTITUTION PERMITTED

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.