

MENTAL HEALTH MEDICATION ENROLLMENT FORM



Connection • Care • Community

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

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

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®	<input type="radio"/> 300 mg syringe <input type="radio"/> 400 mg syringe	Inject _____ mg IM once monthly		
Risperdal Consta®	<input type="radio"/> 12.5 mg kit <input type="radio"/> 25 mg kit <input type="radio"/> 37.5 mg kit <input type="radio"/> 50 mg kit	Inject _____ mg IM every 2 weeks		
Invega Sustenna® Syringe	Initial: <input type="radio"/> 156 mg/mL <input type="radio"/> 234 mg/mL Maintenance: <input type="radio"/> 39 mg/0.25mL <input type="radio"/> 78 mg/0.5mL <input type="radio"/> 117 mg/ 0.75mL <input type="radio"/> 156 mg/mL <input type="radio"/> 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 Relprev® Kit	Initial: <input type="radio"/> 210mg kit <input type="radio"/> 300mg kit <input type="radio"/> 405mg kit Maintenance: <input type="radio"/> 210mg kit <input type="radio"/> 300mg kit <input type="radio"/> 405mg kit	Initial: Inject _____ mg IM every _____ weeks for _____ dose(s) Maintenance: Inject _____ mg IM every _____ weeks		
Invega Trinza®	<input type="radio"/> 273mg <input type="radio"/> 410mg <input type="radio"/> 546mg <input type="radio"/> 819mg	<input type="radio"/> Inject IM every 3 months		
Aristada®	<input type="radio"/> 441 mg 662 <input type="radio"/> 882 mg <input type="radio"/> 1064 mg	<input type="radio"/> Inject IM (deltoid) every month <input type="radio"/> Inject IM (gluteal) every month or 6 weeks <input type="radio"/> Inject IM (gluteal) every 2 months		
Rexulti®	<input type="radio"/> 0.25 <input type="radio"/> 0.5mg <input type="radio"/> 1mg <input type="radio"/> 2mg <input type="radio"/> 3mg <input type="radio"/> 4mg	<input type="radio"/> Take one tablet by mouth daily with or without food		
Vivitrol®	<input type="radio"/> 380 mg syringe	<input type="radio"/> Inject 380 mg every 4 weeks	<input type="radio"/> 1 syringe	

***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.

***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.

Patient's Signature _____ Date _____

Prescriber's Signature _____

PRODUCT SUBSTITUTION PERMITTED