

**1 PATIENT INFORMATION:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender:  M  F Caregiver: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

**2 PRESCRIBER INFORMATION:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Tax I.D.: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**3 STATEMENT OF MEDICAL NECESSITY:**

ICD-10: \_\_\_\_\_  Acute  Chronic  
 Date of Diagnosis: \_\_\_\_\_ Contraindications:  No  Yes  
**Diagnosis Procedure(s) or Laboratory Test(s):**  
 Test/Procedure: \_\_\_\_\_ Date Performed: \_\_\_\_\_ Results: \_\_\_\_\_  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

Prior Failed Treatments:	Length of Treatment:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

**4 INJECTION TRAINING:**

To Be Administered by Pharmacist (State of Missouri Only)  Pharmacist to Provide Training  Patient Trained in MD Office  Manufacturer Nurse Support

**5 PICK UP OR DELIVERY:**

Delivery to Patient's Home  Delivery to Physician's Office  Pharmacy to Coordinate

**6 INSURANCE INFORMATION:** Please Include Front and Back Copies of Pharmacy and Medical Card

**PRESCRIPTION INFORMATION:**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ **Must Provide All Prescription Information**

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> ABILIFY MAINTENA®	<input type="checkbox"/> 300mg Prefilled Syringe <input type="checkbox"/> 400mg Prefilled Syringe <input type="checkbox"/> 300mg Lyophilized Powder <input type="checkbox"/> 400mg Lyophilized Powder	<input type="checkbox"/> _____		
<input type="checkbox"/> ARISTADA INITIO®	<input type="checkbox"/> 675mg Prefilled Syringe	<input type="checkbox"/> <b>Initiation:</b> Inject 1 prefilled syringe IM, by a healthcare professional in the deltoid or gluteal muscle, and take and one 30mg dose of oral aripiprazole in conjunction with the first Aristada injection.		
<input type="checkbox"/> ARISTADA®	<input type="checkbox"/> 441mg Prefilled Syringe <input type="checkbox"/> 662mg Prefilled Syringe <input type="checkbox"/> 882mg Prefilled Syringe <input type="checkbox"/> 1064mg Prefilled Syringe	<input type="checkbox"/> _____		
<input type="checkbox"/> EVZIO®	<input type="checkbox"/> 2mg/0.4ml Autoinjector	<input type="checkbox"/> _____		
<input type="checkbox"/> INVEGA SUSTENNA®	<input type="checkbox"/> 39mg Prefilled Syringe <input type="checkbox"/> 78mg Prefilled Syringe <input type="checkbox"/> 117mg Prefilled Syringe <input type="checkbox"/> 156mg Prefilled Syringe <input type="checkbox"/> 234mg Prefilled Syringe	<input type="checkbox"/> _____		
<input type="checkbox"/> INVEGA TRINZA®	<input type="checkbox"/> 273mg Prefilled Syringe <input type="checkbox"/> 410mg Prefilled Syringe <input type="checkbox"/> 546mg Prefilled Syringe <input type="checkbox"/> 819mg Prefilled Syringe	<input type="checkbox"/> <i>Use INVEGA TRINZA® only after patient has been treated with INVEGA SUSTENNA® for at least four months</i>		
<input type="checkbox"/> PERSERIS™	<input type="checkbox"/> 90mg Prefilled Syringe <input type="checkbox"/> 120mg Prefilled Syringe	<input type="checkbox"/> Inject monthly, S.C., by a healthcare professional in the abdomen, after thoroughly mixing liquid and powder syringes	1	
<input type="checkbox"/> RISPERDAL CONSTA®	<input type="checkbox"/> 12.5mg Vial/Kit <input type="checkbox"/> 25mg Vial/Kit <input type="checkbox"/> 37.5mg Vial/Kit <input type="checkbox"/> 50mg Vial/Kit	<input type="checkbox"/> _____		
<input type="checkbox"/> VIVITROL®	<input type="checkbox"/> 380mg Vial/Kit	<input type="checkbox"/> _____	1	
<input type="checkbox"/> VRAYLAR®	<input type="checkbox"/> 1.5mg Capsules <input type="checkbox"/> 1.5mg & 3mg Mixed Blister Pack <input type="checkbox"/> 3mg Capsules <input type="checkbox"/> 4.5mg Capsules <input type="checkbox"/> 6mg Capsules	<input type="checkbox"/> _____		
<input type="checkbox"/> ZYPREXA® RELPREV™	<input type="checkbox"/> 210mg Vial <input type="checkbox"/> 300mg Vial <input type="checkbox"/> 405mg Vial	<input type="checkbox"/> _____		
<input type="checkbox"/> _____				

**PRESCRIBER SIGNATURE:**

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Substitution Permitted**

**Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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