Long Acting Antipsychotic Injectable Prescription Form
Please complete the form and fax to: 804-628-1533
Pharmacy Phone Number: 1-877-814-3475

Patient Information			Prescriber Information			
Patient Name:			Physician Name:		Practice/Organization Name:	
Date of Birth:	Gender: ☐ Male ☐ Female		Address:			
Address:			City:	State:	Zip Code:	
City:	State:	Zip Code:	Phone#:		Fax#:	
Home Phone:	Work Phone:		DEA:	NPI:	License:	Medicaid UPIN:
Cell Phone:	Email:		Physician Specialty:			
Insurance Information			Date Shipment Needed:	Ship to: ☐ Patient ☐ Prescriber ☐ Infusion Clinic		
ID#:			Shipment Address:			
Group#:	RxBIN:	RxPCN:	City:	State:	Zip Code:	

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis and Clinical Information:

☐ F84.0 Autistic Disorder ☐ F30.__ __ Mood Disorder ☐ F20.__ __ Schizophrenic Disorder ☐ ___.__ __ Description: ____

Date of Diagnosis or Years with Disease: _____________________ Patient Allergies:____ Latex Allergy: ☐ Yes ☐ No

Medical History – Please attach all lab/test results/treatment plans

Comorbidities: ____

Previous and Current Medication Use:

__________________________________ ☐ Current ☐ Failed ☐ Intolerant ☐ Other__________________________________ Dates used: ______________

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Expected First Dose Date: _______________________________________ Injection Instruction needed: ☐ Yes ☐ No

☐ **Abilify Maintena** (aripiprazole extended release injectable suspension)

☐ 300mg ☐ 400mg To be injected IM every month by prescriber as directed.

☐ **Aristada** (aripiprazole extended release injectable suspension)

☐ 441mg ☐ 662mg ☐ 882mg To be injected IM every month by prescriber as directed.

☐ 882mg To be injected IM every 6 weeks by prescriber as directed.

☐ 1,064mg To be injected IM every 2 months by prescriber as directed.

☐ **Invega Sustenna** (paliperidone palmitate extended-release injectable suspension)

☐ 39mg ☐ 78mg ☐ 117mg ☐ 156mg ☐ 234mg To be injected IM every month as directed.

☐ Initiation dose: _____mg IM on day 1, then _____mg IM one week late.

☐ **Invega Trinza** (three-month paliperidone palmitate)

☐ 273mg ☐ 410mg ☐ 546mg ☐ 819mg To be injected IM every 3 months by prescriber as directed.

☐ **Risperdal Consta** (risperidone long-acting injection)

☐ 12.5mg ☐ 25mg ☐ 37.5mg ☐ 50mg To be injected IM every 2 weeks as directed.

Quantity Prescribed: ☐ QS 30 days ☐ Other: ______

Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ 11 ☐ Other:______

Physician Signature (no stamps): ______________________________________ **Date:**_____________________

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