

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
 Diagnosis _____ ICD-9 Code _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____
 Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

<input type="checkbox"/> RISPERDAL CONSTA _____	IM Biweekly	QTY _____	Refills _____
<i>strength</i>			
<input type="checkbox"/> INVEGA SUSTENNA _____	IM Treatment Daily	QTY _____	Refills _____
<i>strength</i>			
<input type="checkbox"/> INVEGA SUSTENNA _____	IM in 1 week (7 days)	QTY _____	Refills _____
<i>strength</i>			
<input type="checkbox"/> INVEGA SUSTENNA _____	IM Monthly (maintenance)	QTY _____	Refills _____
<i>strength</i>			

- Does the patient have a history of noncompliance with a prior oral anti-psychotic regimen? Yes No N/A
 If yes, please attach documentation of what adherence measures were done.
- Has the patient in the past received oral Risperdal or oral Invega without any significant side effects? Yes No
- Does the patient have renal and/or hepatic impairment? Yes No
- What is the requested duration of therapy? < 6 months > 6 months
- Delivery date needed _____ Deliver to Physician Office Patient Home

By signing this form and utilizing our services, you are authorizing Elwyn Specialty and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

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