ENVISIONSPECIALTY

Long Acting Psychotropic Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

☐ **New to Therapy**
☐ **Current Therapy**

Patient Information

Patient Name: _____
Date of Birth: _____ Sex: M or F Caregiver:_____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder:_____
Policy holder Employer:_____
Relationship to Patient:_____
ID# _____Group#_____
RxBIN: _____RxPCN:_____

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name:_____
Address:_____
City: _____State: _____ Zip: _____
Phone#:_____Fax#:_____
DEA#_____NPI#_____
License#:_____Medicaid UPIN#:_____
Physician Specialty: _____
Date Shipment Needed: _____
Ship to: ☐ Patient ☐ Prescriber ☐ Other:_____
Shipment Address: _____Attn: _____
City: _____State: _____Zip:_____
If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis: ☐ F84.0 Autistic Disorder ☐ F30.__ __ Mood Disorder
☐ F20.__ __ Schizophrenic disorder ☐ _ _ _ . _ _ Description: _____
Date of Diagnosis or Years with Disease: _____
Patients Allergies: _____
Latex allergy: ☐Yes ☐No Patient Weight: _____ Patient Height: _____
Medical History -Please attach all lab/test results/treatment plans
Comorbidities: _____
Previous and Current Medication Use:
_____☐Current ☐Failed ☐Intolerant ☐Other:_____ Dates used: _____
_____☐Current ☐Failed ☐Intolerant ☐Other:_____ Dates used: _____
_____☐Current ☐Failed ☐Intolerant ☐Other:_____ Dates used: _____

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 later

☐ **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.

☐ **Zyprexa® Relprevv™** (olanzapine extended-release injectable suspension)
☐ 210mg ☐ 300mg To be injected IM every 2 weeks by prescriber as directed.
☐ 405mg To be injected IM every 4 weeks by prescriber as directed.

Quantity Prescribed: ☐ QS 30 days ☐ Other: _____
Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ 11 ☐Other: _____
Signature: *X*_____ Date: _____/_____/_____