

Patient Information	Clinical Information and Prescription
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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: _____

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

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.

- 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: ____/____/____

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.