ANTIPSYCHOTIC PRESCRIPTION FORM

151 Cochituate Rd | Framingham, MA 01701
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Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

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 ☐ V-Care Pharmacy Date Needed ________

Diagnosis ________ ICD-10 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

☐ **RISPERDAL CONSTA** ________ IM Biweekly QTY ________ Refills ________
strength

☐ **INVEGA SUSTENNA** ________ IM Treatment Daily QTY ________ Refills ________
strength

☐ **INVEGA SUSTENNA** ________ IM in 1 week (7 days) QTY ________ Refills ________
strength

☐ **INVEGA SUSTENNA** ________ IM Monthly (maintenance) QTY ________ Refills ________
strength

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

By signing this form and utilizing our services, you are authorizing V-Care Pharmacy and it's 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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Please fax completed referral form to **V-Care Pharmacy & Surgical Supplies** at **508.202.9343** Visit us at **WWW.MYVCAREPHARMACY.COM** for online fillable forms.

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