ANTIPSYCHOTIC PRESCRIPTION FORM

V-Care Pharmacy
Specialty + Medical & Surgical Supplies
151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | Fx 508.202.9343

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

☐ **ARISTADA**	Strength: ☐ 441 mg ☐ 662 mg ☐ 882 mg ☐ 1064 mg	IM ___weeks Sig:	QTY: Refills
☐ **ABILIFY MAINTENA**	Strength: ☐ 300 mg ☐ 400 mg	IM 4 weeks Sig:	QTY: Refills
☐ **RISPERDAL CONSTA**	Strength: ☐ 12.5 mg ☐ 25 mg ☐ 37.5 mg ☐ 50 mg	IM Biweekly	QTY: Refills
☐ **INVEGA SUSTENNA**	Strength: ☐ 39 mg ☐ 78 mg ☐ 117 mg ☐ 156 mg ☐ 234 mg	IM initiation day 1 dose	QTY: Refills
☐ **INVEGA SUSTENNA**	Strength: ☐ 39 mg ☐ 78 mg ☐ 117 mg ☐ 156mg ☐ 234 mg	IM initiation day 8 dose	QTY: Refills
☐ **INVEGA SUSTENNA**	Strength: ☐ 39 mg ☐ 78 mg ☐ 117 mg ☐ 156 mg ☐ 234 mg	IM maintenance monthly dose	QTY: Refills
☐ **INVEGA TRINZA**	Strength: ☐ 273 mg ☐ 410 mg ☐ 546 mg ☐ 819 mg	Sig:	QTY: Refills
☐ **ZYPREXA RELPREVV**	Strength: ☐ 210 mg/vial ☐ 300 mg/vial ☐ 405 mg/vial	Sig:	QTY: Refills

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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