☐ NEW PATIENT ☐ CURRENT PATIENT

ANTIPSYCHOTIC PRESCRIPTION FORM

151 Cochituate Rd | Framingham, MA 01701
PHONE: 508-202-9993 | FAX: 508-202-9343 | 844-7-MYVCARE

Patient Name ______ D.O.B ______ Weight ______ ☐ Male ☐ Female
Address ______ City ______ State ______ Zip ______
Daytime Telephone ______ Evening Telephone ______ Cell ______ Email ______
Ship to patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ V-Care Pharmacy Date Needed ______
ICD-10 Code ______ Diagnosis ______ Allergies ______
Testing ☐ Yes ☐ No Results ______ Patient currently on therapy ☐ Yes ☐ No Date of next blood work ______

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

Drug	Strength							
☐ **ARISTRADA**	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	☐ 156 mg	☐ 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
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 haptic 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

This is **not** a valid prescription and is intended for reference only. For providers: **Please send a valid prescription electronically or via fax.**

Prescriber's Signature (no stamps) ______ **Date** ______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.