Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

Antipsychotic Enrollment Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821 Single Point of Contact: (724) 515-7053

1. Patient Information

Start Date:______________ **Ship to:** ___Patient ___Office __________Other

Patient Name:____________________________________ M / F DOB:______________ Weight:_________

Address: ____ SSN: _____________

Phone:_____________________ Alt Phone:_____________________ Caregiver:__________________

Allergies: __________________________________Comorbidities: _____________________________

2. Clinical Information: *Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10/ Diagnosis Code:______________________ Other Info: ____________________________________

3. Prescription Information *If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

✗	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
	Abilify Maintena®	__ 300mg Kit __ 400mg Kit __	__ inject _____mg IM once a month *** Dose adjust based on concomitant therapy *** __	__ 1 Kit __	
	Aristada®	__441mg Kit __662mg Kit __882mg Kit __1064mg Kit	__ inject ______ mg IM every _________ weeks	__ 1 Kit =(5mL)PFS	
	Invega Sustenna®	Starter Dose: __ 156mg/1mL PFS __ 234mg/1.5mL PFS	__ inject 234mg IM on day 1 then 156mg IM 1week later __	__ 1 PFS __	
		Maintenance Dose: __ 39mg/0.25mL PFS __ 78mg/0.5mL PFS __ 117mg/0.75mL PFS __ 156mg/1mL PFS __ 234mg/1.5mL PFS	__ inject _______mg IM once a month __	__1 PFS __	
	Latuda®	__ 20mg __ 40mg __ 60mg __ 80mg __ 120mg	__ take 1 tablet by mouth daily __	__ 30 tablets __	
	Pristiq®	__ 25mg __ 50mg __100mg	__take 1 tablet by mouth daily __	__ 30 tablets __	
	Rexulti®	__0.25mg __0.5mg __1mg __2mg __3mg __4mg	__ take ________mg by mouth daily __	_____ tablets	
	Risperdal Consta®	__ 12.5mg/ 5mL Kit __ 25mg/ 2mL Kit __ 37.5mg/2mL Kit __ 50mg/ 2mL Kit	__ inject _______mg IM every 2 weeks __	__ 1 Kit	
	Zyprexa Relprevv®	__ 210mg / Vial __ 300mg / Vial __ 405mg /Vial	__inject ______mg IM every ___ weeks __	__ 210mg Kit __ 300mg Kit __ 405mg Kit	

4. Prescriber and Shipping Information

Pref. Method of Contact: __phone __fax __email

Prescriber (print) : ________________________________ Office Contact: ______________________

Contact email:_________________________________ Phone: ____________________________

Office Address:____

Fax:__________________________ NPI:___________________ DEA#:__________________________

Prescriber Signature:____ Date: ______________

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information

Please fax a copy of insurance card front and back. Enlarge if possible.

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