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

AccuSERV® PHARMACY

Antipsychotic Enrollment Form

Clear 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 ○	
	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.

Please fax completed form to AccuServ Pharmacy at (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.