

Injectable Anti-Psychotics



toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient information Prescriber + Shipping Information

Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____	Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to prescriber: <input type="checkbox"/> 1st Fill <input type="checkbox"/> Always <input type="checkbox"/> Never
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Insurance Information (Please fax a copy of front and back of the insurance cards)

1° Insurance Plan: _____	Plan ID #: _____	Policy Holder: _____	Relation: _____
2° Insurance Plan: _____	Plan ID #: _____	Policy Holder: _____	Relation: _____

Clinical Information (Please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code:

F10.2 Alcohol Dependence F11.2 Opioid Dependence

F20 Schizophrenia F31 Bipolar Disorder F32 Major Depressive Disorder

Comorbidities: _____
 Allergies: NKDA Other: _____

Prescription information

<input type="checkbox"/> Abilify Maintena® <small>(aripiprazole)</small>	Strength: _____ Qty: _____ Directions: _____ Refills: _____
<input type="checkbox"/> Aristada® Prefilled Syringe <small>(aripiprazole lauroxil)</small>	Strength: _____ Qty: _____ Directions: _____ Refills: _____
<input type="checkbox"/> Invega Sustenna® <small>(paliperidone palmitate)</small>	Strength: _____ Qty: _____ Directions: _____ Refills: _____
<input type="checkbox"/> Invega Trinza® <small>(paliperidone palmitate)</small>	Strength: _____ Qty: _____ Directions: _____ Refills: _____
<input type="checkbox"/> Vivitrol® <small>(Naltrexone)</small>	Strength: _____ Qty: _____ Directions: _____ Refills: _____
<input type="checkbox"/> Risperdal Consta® <small>(Risperidone)</small>	Strength: _____ Qty: _____ Directions: _____ Refills: _____
<input type="checkbox"/> Zyprexa Relprevv® <small>(Olanzapine)</small>	Strength: _____ Qty: _____ Directions: _____ Refills: _____
<input type="checkbox"/> Perseris® <small>(Risperidone)</small>	Strength: _____ Qty: _____ Directions: _____ Refills: _____
_____	Strength: _____ Qty: _____ Directions: _____ Refills: _____

Thrifty White offers injection administration (ND and IA) and training (SD, MT, and MN) in our stores. Would you like the pharmacy to perform this service? Yes No Next Injection Due Date: _____

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature: _____ Date: _____
I authorize Thrifty White Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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