Injectable Anti-Psychotics

Employee Owned
Thrifty White PHARMACY
Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑ kg ❑ lbs Ht:_____ ❑ cm ❑ in
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____

Prescriber + Shipping Information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address: _____
If shipping to presciber: ❑ 1st Fill ❑ Always ❑ Never

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

☐ **Abilify Maintena®** (aripiprazole)	Strength: _____ Qty: _____ Directions: _____ Refills: _____
☐ **Aristada® Prefilled Syringe** (aripiprazole lauroxil)	Strength: _____ Qty: _____ Directions: _____ Refills: _____
☐ **Invega Sustenna®** (paliperidone palmitate)	Strength: _____ Qty: _____ Directions: _____ Refills: _____
☐ **Invega Trinza®** (paliperidone palmitate)	Strength: _____ Qty: _____ Directions: _____ Refills: _____
☐ **Vivitrol®** (Naltrexone)	Strength: _____ Qty: _____ Directions: _____ Refills: _____
☐ **Risperdal Consta®** (Risperidone)	Strength: _____ Qty: _____ Directions: _____ Refills: _____
☐ **Zyprexa Relprevv®** (Olanzapine)	Strength: _____ Qty: _____ Directions: _____ Refills: _____
☐ **Perseris®** (Risperidone)	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.