Elwyn SPECIALTY CARE
A BIOMATRIX Company

LONG-ACTING INJECTABLE ATYPICAL ANTIPSYCHOTIC

3070 McCann Farm Drive | Suite 101 | Garnet Valley, PA 19060
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

FEB 2018

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

Diagnosis ICD-10 Code

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

ABILIFY MAINTENA* ☐ 300 mg syringe ☐ 400 mg syringe
SIG: Inject _____ mg IM once monthly
QTY _____ Refills _____
**Dose adjust based on concomitant therapy*

RISPERDAL CONSTA
☐ 12.5 mg kit ☐ 25mg kit ☐ 37.5 mg kit ☐ 50 mg kit
SIG: Inject _____ mg IM every 2 weeks
QTY _____ Refills _____

PRISTIQ ☐ 25mg ☐ 50mg ☐ 100mg
SIG: Take _____ mg by mouth once daily
Other: _____ QTY _____ Refills _____

LATUDA ☐ 20mg ☐ 40mg ☐ 60mg ☐ 80mg ☐ 120mg
Take _____ mg by mouth once daily
Other: _____ QTY _____ Refills _____

INVEGA SUSTENNA SYRINGE
Initial Dosage: ☐ Inject 234 mg IM on treatment day 1, then 156 mg IM 1 week later.
Please specify quantity of each for starter dose:
_____ 156 mg/mL _____ 234 mg/mL
Maintenance: ☐ Inject _____mg IM every month
QTY for maintenance: _____ 39 mg/0.25mL _____ 78 mg/0.5mL
_____ 117 mg/ 0.75mL _____ 156 mg/mL _____ 234 mg/mL
Refills _____

ZYPREXA RELPREVV KIT
Initial dosage: ☐ Inject _____ mg IM every _____ weeks for _____ dose(s)
Please specify quantity for starter dose:
_____ 210mg kit _____ 300mg kit _____ 405mg kit
Maintenance: ☐ Inject _____ mg IM every _____ weeks
QTY for maintenance dose: _____ 210mg kit _____ 300mg kit _____ 405mg kit
Refills _____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) **Date**

NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS USING LONG-ACTING INJECTABLE ATYPICAL ANTIPSYCHOTICS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc…)
- ☐ Medication list and allergies
- ☐ Insurance information with RX insurance. Please include copy of card
  If the only card included is a medical card, please include local pharmacy information
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills
- ☐ MD signature and date on referral form
- ☐ Previous treatment
- ☐ Clinical notes

Does the patient have a history of noncompliance with a prior oral anti-psychotic regimen?
☐ Yes ☐ No ☐ N/A
If yes, please attach documentation of what adherence measures were done.

Has the patient taken the appropriate oral antipsychotic without any significant side effects? ☐ Yes ☐ No

Does the patient have renal and/or hepatic impairment? ☐ Yes ☐ No

What is the requested duration of therapy? ☐ < 6 months ☐ > 6 months

Fax the requested documentation to (610) 545-6030

Toll Free: 1-855-ELWYN-RX (359-9679) Direct Phone: (610) 545-6040

ElwynSpecialtyCare.com

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