CENTRAL Pharmacy

Call: 617-254-5900

BEHAVIORAL HEALTH SPECIALTY CARE PROGRAM

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY:

ICD-10: _____ ❑ Acute ❑ Chronic
Date of Diagnosis: _____ Contraindications: ❑ No ❑ Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
1.		
2.		
3.		

If Prior Authorization is Denied:
❑ Automatically Draft Appeal for Review ❑ Send Preferred Formulary Alternatives

Prior Failed Treatments:	Length of Treatment:

4 PRESCRIPTION INFORMATION:

Medication	Dosage & Strength	Direction	QTY	Refills
❑ ABILIFY MAINTENA®	❑ 300mg Lyophilized Powder ❑ 400mg Lyophilized Powder	❑ Inject 5-10mg once a day ❑ Inject 10mg once a day ❑ Inject 10-15mg once a day ❑ Inject 15mg once a day	1 Kit	
❑ ARISTADA®	❑ 441mg Prefilled Syringe ❑ 662mg Prefilled Syringe ❑ 882mg Prefilled Syringe	❑ Inject 441mg IM every 4 weeks ❑ Inject 662mg IM every 4 weeks ❑ Inject 882mg IM every 4 weeks ❑ Inject 882mg IM every 6 weeks	1 Kit	
❑ EVZIO®	❑ 0.4mg/0.4ml Autoinjector	❑ Inject 0.4mg IM or SC every 2 to 3 minutes until emergency medical assistance is present	❑ 1 Carton ❑ 2 Cartons	
❑ INVEGA SUSTENNA®	❑ 39mg Prefilled Syringe ❑ 78mg Prefilled Syringe ❑ 117mg Prefilled Syringe ❑ 156mg Prefilled Syringe ❑ 234mg Prefilled Syringe	❑ **Induction Dose:** Inject 234mg IM on day 1, then 156mg IM on day 8, then switch to maintenance dosing ❑ **Maintenance:** Inject 39-234mg IM once a month	1 Kit	0
❑ RISPERDAL CONSTA®	❑ 12.5mg Vial/Kit ❑ 25mg Vial/Kit ❑ 37.5mg Vial/Kit ❑ 50mg Vial/Kit	❑ Inject 25mg IM every 2 weeks	1 Pack	
❑ VIVITROL®	❑ 380mg Vial/Kit	❑ Inject 380mg every 4 weeks	1 Carton	
❑ ZYPREXA RELPREVV™	❑ 210mg Vial ❑ 300mg Vial ❑ 405mg Vial	❑ Inject 210mg every 2 weeks ❑ Inject 300mg every 2 weeks ❑ Inject 300mg every 4 weeks ❑ Inject 405mg every 4 weeks	1 Kit	
❑ _____	_____	_____		

5 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PRODUCT DELIVERY: ❍ MD Authorizes Delivery to Patient Home ❍ Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.