Fax: 866-926-0463

Phone: 855-427-4682

Injectable Psychotropic Medication Enrollment Form

(Please use black ink)

PATIENT INFORMATION *Please complete the following or* ***send patient demographic sheet***

Patient Name ______ SSN ______

Insurance ID ______ Birth Date ______ Height ______ Weight ______

Address ______ Apartment # ______

City ______ State ______ Zip ______

Phone Number ______ Alternate Phone ______ Gender ☐ Male ☐ Female

☐ Check here if patient has a legal representative and attach appropriate legal documentation.

PRESCRIBING PHYSICIAN

Name ______ NPI ______ DEA ______

Address ______ Suite # ______ City ______ State & Zip ______

Phone Number ______ Fax Number ______

Alternative Contact Name ______ Phone Number ______ Extension ______

PRIMARY INSURANCE INFORMATION

Insurance Name ______

Insurance Phone ______

Subscriber Name ______

Subscriber ID # ______

Group # ______

SECONDARY INSURANCE INFORMATION

Insurance Name ______

Insurance Phone ______

Subscriber Name ______

Subscriber ID # ______

Group # ______

Please attach a copy of the front and the back side of the member's insurance card

Optum Behavioral Health Case Manager Name ______ Phone Number ______

Dates of Authorization: Start Date ______ End Date ______

LOCATION OF ADMINISTRATION AND SHIPPING INFORMATION

Location of Administration ______ NPI ______ DEA ______

Address ______ Suite # ______ City ______ State & Zip ______

Phone Number ______ Fax Number ______

Date Medication Needed ______ Additional Shipping Instructions? ☐ Yes ☐ No If YES please specify ______

Medication Instructions (for pharmacy) Is This Medication a New Start? ☐ Yes ☐ No If NO please provide ______

Initiation date ______ Date of last dose ______

Ancillary Supplies Provided As Needed for Administration

DIAGNOSIS INFORMATION

ICD-10 Code(s) ______ Diagnosis ______

J-Code ______

☐ Abilify Maintena® (aripiprazole)
☐ Aristada (aripiprazole lauroxil)
☐ Haldol® Decanoate (haloperidol deconate)
☐ Invega® Sustenna® (paliperidone palmitate)
☐ Prolixin® (fluphenazine decanoate)
☐ Risperdal® Consta® (risperidone)
☐ Vivitrol® (naltrexone IM)
☐ Zyprexa® Relprevv™ (olanzapine)
☐ Other ______

Dose / Strength	Directions	Quantity	Refills

**Prescriber Authorization:* I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: ☐ Patient ☐ Office ☐ Other ______ Date ______ Needs by Date ______

Prescriber's Signature ______ ______

PRODUCT SUBSTITUTION PERMITTED *DISPENSE AS WRITTEN*

Supervising Physician / Supervising Physician Signature ______

Patient Authorization: I authorize BriovaRx Specialty Pharmacy to bill my insurance company for this prescription and refills of this prescription. I understand that I am financially responsible for any co-pay/co-insurance amounts or other amounts not covered by my insurance. I understand that either I or my authorized representative will need to contact BriovaRx Specialty Pharmacy if there are changes in my insurance or I no longer need this prescription.

I authorize this prescription and all refills of this prescription to be shipped to my physicians office at the address below.

Physicians Name ______ Address 1 ______

Signature of patient or patient's authorized representative ______ Address 2 ______

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.