



Fax: 877-342-4596
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

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) 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 Optum® 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 Optum® 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 _____

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