

Psych Enrollment Form

PATIENT INFORMATION:	Prescriber Information:
Patient's Name:	Prescriber's Name:
Address:	DEA:
City, State, Zip Code:	NPI:
Home Phone:	Address:
Alternate Phone:	City, State, Zip Code:
DOB:	Phone:
Last 4 Digits of SS#:	Fax:
Gender:	Contact Person:
Language Preference:	Contact Person's Phone:

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

Prior Authorization Reference #: _____

MEDICAL INFORMATION: (may attach separate sheet if needed)				
Diagnosis: Please include diagnosis and ICD-10 code	Additional information:			
F60.9 Personality disorder, unspecified	Therapy: 🗌 New 🔄 Reauthorization 🔄 Restart			
F06.1 Catatonic disorder due to known physiological	Weight: kg/lb Height cm/in			
condition	Allergies:			
F42.2 Mixed obsessional thoughts and acts	Lab Data:			
F20.2 Catatonic schizophrenia	Prior Therapies:			
Other Diagnosis:	Concomitant Medications:			
ICD-10 Code:				
Description:	Injection Training Required: 🗌 Yes 🗌 No			
J-Code:				
	Start Date Review Date			

Prescription Information						
Medication	Dose	Directions	Quantity	Refills		
Abilify Maintena®						
Aristada®						
Haldol [®] Decanoate						
Invega Sustenna®						
Prolixin®						
Risperdal [®] Consta [®]						
Vivitrol®						
Zyprexa [®] Relprevv™						
OTHER:						
Please deliver to: Patient Office Other by this date:						
Procession Authorization Louthorization she pharmany and its consecutatives to act as my authorized agant to social agant to social and initiate the insurance prior authorization process for my patient/s) and						

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 patient's choice or in the patient's insurer's provider network.

Product Substitution Permitted Dispense as Written

Prescriber's Signature: _

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