



LONG-ACTING INJECTABLE ATYPICAL ANTIPSYCHOTIC

1299 McCarter Hwy Newark, NJ 07104

Tel 973-485-8522 Fax: 973-485-8570

Only servicing patients residing in the state of New Jersey

Today's Date _____

NEW PATIENT CURRENT PATIENT

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-9 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

RISPERDAL CONSTA _____ IM Biweekly QTY _____ Refills _____
strength
 INVEGA SUSTENNA _____ IM Treatment Daily QTY _____ Refills _____
strength
 INVEGA SUSTENNA _____ IM in 1 week (7 days) QTY _____ Refills _____
strength
 INVEGA SUSTENNA _____ IM Monthly (maintenance) QTY _____ Refills _____
strength

- 1. 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.
- 2. Has the patient in the past received oral Risperdal or oral Invega without any significant side effects? Yes No
- 3. Does the patient have renal and/or hepatic impairment? Yes No
- 4. What is the requested duration of therapy? < 6 months > 6 months
- 5. Delivery date needed _____ Deliver to Physician Office Patient Home

By signing this form and utilizing our services, you are authorizing Trimax 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** _____

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