TRIMAX PHARMACY
Sports Nutrition & Supplements

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** _____ *strength* IM Biweekly QTY _____ Refills _____

☐ **INVEGA SUSTENNA** _____ *strength* IM Treatment Daily QTY _____ Refills _____

☐ **INVEGA SUSTENNA** _____ *strength* IM in 1 week (7 days) QTY _____ Refills _____

☐ **INVEGA SUSTENNA** _____ *strength* IM Monthly (maintenance) QTY _____ Refills _____

1. Does the patient have a history of noncompliance with a prior oral anti-psychotic regimen? ☐ Yes ☐ No ☐ N/A
   If yes, please attach documentationof 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** _____