Riverview PHARMACY
"Big Enough to Serve You...
Small Enough to Know You..."

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LONG-ACTING INJECTABLE ATYPICAL ANTIPSYCHOTIC

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Today's Date _____ /_____ /_____ Are you a new patient? ☐ Yes ☐ No
Patient Name _____ DOB _____ /_____ /_____
Emergency Phone _____ Date Needed _____ /_____ /_____
Address Line 1 _____
Address Line 2 _____
City _____ State _____ Zip _____
Phone _____ Cell _____
Email Address _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at
☐ Physician Office ☐ Riverview Pharmacy ☐ Valley Pharmacy
Allergies _____
Comorbidities _____
Current Medications (please fax a complete list if necessary) _____
_____

ICD-10 Diagnosis Code: ☐ _____ ☐ _____
Diagnosis _____
Previously treated for this condition? ☐ Yes ☐ No
Medication(s) failed _____
Patient currently on therapy? ☐ Yes ☐ No
Type/medication(s) _____

Insured's Name _____ Relation _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare # _____
Prescription Card ☐ Yes ☐ No If yes, Carrier _____
Phone _____ Fax _____
Policy/Group# _____
Bin# _____ PCN# _____
RXID# _____ RX Group# _____

Prescriber's Name / Practice _____
Office Contact _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
Email _____
License# _____ NPI# _____
UPIN#_____ DEA#_____

☐ **ABILIFY MAINTENA** ☐ 300 mg ☐ 400 mg

☐ Pre-filled Dual Chamber Syringe ☐ Vial

SIG: _____

☐ **RISPERDAL CONSTA** _____ IM Biweekly
strength

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

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

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

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 documentation of what adherence measures were done.

Has the patient in the past received oral Risperdal or oral Invega without any significant side effects?
☐ Yes ☐ No

2. Does the patient have renal and/or hepatic impairment?
   ☐ Yes ☐ No
3. What is the requested duration of therapy?
   ☐ < 6 months ☐ > 6 months

Please sign and fax completed referral form to Riverview Pharmacy at **973-831-4081**
For this and other referral forms in online formats, visit **www.RiverviewPharmacyNJ.com**

Prescriber's Signature _____ Date _____ /_____ /_____
(actual signature required)