

Patient Information

Patient Name: _____
 Date of Birth: _____ Sex: _____ Caregiver: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____
 Please attach copy of front and back of patient's prescription ins. card(s) if applicable
 Insurance Company Name: _____
 Insurance Company Phone: _____
 Policy holder: _____
 Policy holder Employer: _____
 Relationship to Patient: _____
 ID# _____ Group# _____
 RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____
 Prescriber Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone#: _____ Fax#: _____
 DEA# _____ NPI# _____
 License#: _____ Medicaid UPIN#: _____
 Physician Specialty: _____
☐ **Please indicate if prescriber is from a Community Service Board**
 Date Shipment Needed: _____
 Ship to: ☐ Patient ☐ Prescriber ☐ Other: _____
 Shipment Address: _____ Attn: _____
 City: _____ State: _____ Zip: _____
If shipped to the prescriber's office, Prescriber accepts on behalf of patient for administration in office.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee the recipient should immediately notify the sender at the address and telephone number set forth herein and obtains instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee by express authority of the sender to the named addressee. Orchard Pharmaceutical Services, Inc. 6-2013

Clinical Information and Prescription

Diagnosis: ☐ 299.0 Autistic Disorder ☐ 296. __ __ Mood Disorder
☐ 295. __ __ Schizophrenic disorder ☐ __ __ . __ __ Description: _____
 Date of Diagnosis or Years with Disease: _____
 Patients Allergies: _____
 Latex allergy: ☐ Yes ☐ No
 Patient Weight: _____ Patient Height: _____

Medical History -Please attach all lab/test results/treatment plans
Comorbidities:
Previous and Current Medication Use:

_____	☐ Current	☐ Failed	☐ Intolerant	☐ Other: _____	Dates used: _____
_____	☐ Current	☐ Failed	☐ Intolerant	☐ Other: _____	Dates used: _____
_____	☐ Current	☐ Failed	☐ Intolerant	☐ Other: _____	Dates used: _____

Pediatric Patient: Participating in a Behavioral Management Program? ☐ Yes ☐ No

Expected First Dose Date: _____ Injection Instruction needed: ☐ Yes ☐ No

☐ **Risperdal® Consta®** (risperidone long-acting injection)

☐ 12.5mg ☐ 25mg ☐ 37.5mg ☐ 50mg

To be injected IM every 2 weeks as directed.

☐ **Invega® Sustenna®** (paliperidone palmitate extended-release injectable suspension)

☐ 39mg ☐ 78mg ☐ 117mg ☐ 156mg ☐ 234mg

To be injected IM every month as directed.

☐ Initiation dose: _____ mg IM on day 1, then _____ mg IM one week later

☐ **Abilify Maintena™** (aripiprazole extended release injectable suspension)

☐ 300mg ☐ 400mg

To be injected IM every month by prescriber as directed.

☐ **Zyprexa® Relprevv™** (olanzapine extended-release injectable suspension)

☐ 210mg ☐ 300mg **To be injected IM every 2 weeks by prescriber as directed.**

☐ 405mg **To be injected IM every 4 weeks by prescriber as directed.**

☐ **Haloperidol Decanoate:** _____ mg IM every _____

☐ **Fluphenazine Decanoate:** _____ mg IM or SC (circle) every _____

Quantity Prescribed: ☐ QS 30 days ☐ Other: _____

Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ 11 ☐ Other: _____

Signature: X _____ **Date:** ____/____/____