Invega (Paliperidone)

DELIVERIT™ Infusion & Specialty

Patient Demographic Information

Patient Name		**DOB**		**Gender**	Male ☐ Female ☐	**Weight**	____ lbs ☐ kg ☐
SSN		**Phone**		**Allergies**			
Address		**City**		**State**		**Zip Code**	
ICD-10 Diagnosis Code		**Diagnosis**					
Allergies (Please note reaction)					☐ **Latex**		
Current Medications							
Comorbidities							

Patient Insurance Information

Primary Insurance		**Name of the Insured**		**Relationship**	
Member ID#		**Group #**		**Insurance Phone #**	
Secondary Rx Carrier		**Rx ID #**		**Rx Group #**	

Drug Therapy Information

Medication	Directions	Quantity	Refills
Invega Sustenna (paliperidone)	☐ Loading Dose (Day 1): Administer **234mg** IM (deltoid) on treatment day 1 ☐ Follow Up Dose (Day 8): Administer **156mg** IM (deltoid) on treatment day 8 **Invega Sustenna:** ☐ Administer **39mg/0.25mL** IM (deltoid/VG) every 4 weeks ☐ Administer **78mg/0.5mL** IM (deltoid/VG) every 4 weeks ☐ Administer **117mg/0.75mL** IM (deltoid/VG) every 4 weeks ☐ Administer **156mg/1mL** IM (deltoid/VG) every 4 weeks ☐ Administer **234mg/1.5mL** IM (deltoid/VG) every 4 weeks	☐ **1 Kit**	
Invega Trinza (paliperidone)	☐ Administer **273mg/0.875mL** IM every 3 months ☐ Administer **410mg/1.315mL** IM every 3 months ☐ Administer **546mg/1.75mL** IM every 3 months ☐ Administer **819mg/2.625mL** IM every 3 months	☐ **1 Syringe**	
Invega Hafyera (paliperidone)	☐ Administer 1092mg/3.5mL IM every 6 months ☐ Administer 1560mg/5mL IM every 6 months	☐ **1 Syringe**	

Treatment History

☐ **New to Therapy** ☐ **Continuation of Therapy**

Infusion

☐ **Infused at MDO** ☐ **Infused at Home** (Nursing visits required)

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Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	
Email Address		DEA#		State License#			
Group/Hospital							

Delivery Information

☐ **Ship to Patient**

☐ **Pick at Deliverit Pharmacy**

☐ **Ship to Prescriber/Clinic**

☐ **Pharmacy may administer**

Date Medication Needed: _____

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Date

Prescriber's Signature

X _____