Mental Health

Referral Form

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____ lbs ☐ kg ☐
SSN		Phone		Email		Alternate Contact/Care Partner	
Address		City		State		Zip Code	
US Resident: ☐ Yes ☐ No		ICD-10 Diagnosis Code		Diagnosis			
Allergies (Please note reaction)						☐ Latex	
Current Medications							
Comorbidities							
Patient/ Authorized Representative's Signature				Date			
Description of Authorized Representative's Authority:							
(Optional) I consent to have my prescription shipped to :	☐ Care Partner	☐ LTC	☐ HCP Office	☐ Group Home			
Patient Residence Category :	☐ At Home	☐ LTC	☐ Group Home	☐ Other			

Patient Insurance Information

Primary Insurance		Name of the Insured		Relationship			
Member ID#		Group #		Insurance Phone #			
Secondary Rx Carrier		Rx ID #		Rx Group #			
Policy Holder DOB		Phone		Bin#		PCN	
Payer Type	☐ Commerical	☐ Medicare	☐ Medicaid	☐ Other	☐ Patient Does Not Have Insurance		

Invega 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 **Maintenance Dose (Day 8):** ☐ 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	

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Prescription for Austedo XR

ICD-10 Code ☐ G24.01 Tardive Dyskinesia (TD) ☐ G10 H ICD-10CODE untington's Chorea (HD) ☐ Other ICD-10

☐ 4-Week TITRATION KIT

NDC: 68546-490-52

12 mg once-daily x Week 1

18 mg (12mg + 6mg) once-daily x Week 2

24 mg once-daily x Week 3

30 mg (24 mg + 6mg) once-daily x Week 4

Apply 30-day free trial voucher

☐ CONTINUING & SAMPLED PATIENTS

Titrate weekly by 6mg/day from current dose _____ mg/day reach the dose selected below (select one):

☐ 24 mg/day

☐ 30 mg/day

☐ 36 mg/day-Does selection following intial 4-week titration

Refills# _____

Prescriberipton For INGREZZA (valbenazine) Capsules

Intial Rx

☐ 40 mg once daily x 7 then 80 mg once daily x 21

☐ 40 mg once daily x 14 then 60mg once daily x 14 (Huntington's chorea)

Primary Diagnosis Code Category

Maintenance Rx

☐ 40 mg once daily ,1-month supply

☐ 60 mg once daily ,1-month supply

☐ 80 mg once daily ,1-month supply Refill# _____

☐ Other Rx Sig:_____ Quantity_____ Other Rx Refill _____

Clinical Information

Primary Diagnosis Code Category:

☐ Tardive dyskinesia(G24.01) ☐ Huntington's chorea (G10)

☐ Other Diagnosis _____ ☐ Allergies _____

Delivery Information

☐ **Ship to Patient**

☐ **Pick at Deliverit Pharmacy**

☐ **Ship to Prescriber/Clinic**

☐ **Pharmacy may administer**

Date Medication Needed: _____

Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	

☐ 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_____