



844.840.1758 | 844.840.1759 |  
 contact@medboxrx.com | www.medboxrx.com

# PSYCHOLOGY FORM

(Please use black ink)

## PATIENT INFORMATION Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_ SSN \_\_\_\_\_  
 Insurance ID \_\_\_\_\_ Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Address \_\_\_\_\_ Apartment # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Alternate Phone \_\_\_\_\_ Gender  Male  Female  
 Check here if patient has a legal representative and attach appropriate legal documentation.

## PRESCRIBING PHYSICIAN

Name \_\_\_\_\_ NPI \_\_\_\_\_ DEA \_\_\_\_\_  
 Address \_\_\_\_\_ Suite # \_\_\_\_\_ City \_\_\_\_\_ State & Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  
 Alternative Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Extension \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Insurance Name \_\_\_\_\_  
 Insurance Phone \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber ID # \_\_\_\_\_  
 Group # \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Insurance Name \_\_\_\_\_  
 Insurance Phone \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber ID # \_\_\_\_\_  
 Group # \_\_\_\_\_

**\*\*Please attach a copy of the front and the back side of the member's insurance card\*\***

Optum Behavioral Health Case Manager Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Dates of Authorization: Start Date \_\_\_\_\_ End Date \_\_\_\_\_

## LOCATION OF ADMINISTRATION AND SHIPPING INFORMATION

Location of Administration \_\_\_\_\_ NPI \_\_\_\_\_ DEA \_\_\_\_\_  
 Address \_\_\_\_\_ Suite # \_\_\_\_\_ City \_\_\_\_\_ State & Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  
 Date Medication Needed \_\_\_\_\_ Additional Shipping Instructions?  Yes  No If YES please specify \_\_\_\_\_  
**Medication Instructions (for pharmacy)** Is This Medication a New Start?  Yes  No If NO please provide \_\_\_\_\_  
 Initiation date \_\_\_\_\_ Date of last dose \_\_\_\_\_

**\*\*Ancillary Supplies Provided As Needed for Administration\*\***

## DIAGNOSIS INFORMATION

ICD-10 Code(s) \_\_\_\_\_ Diagnosis \_\_\_\_\_  
 J-Code \_\_\_\_\_

Abilify Maintena® (aripiprazole)  Aristada (aripiprazole lauroxil)  Haldol® Decanoate (haloperidol deconate)  
 Invega® Sustenna® (paliperidone palmitate)  Prolixin® (fluphenazine decanoate)  Risperdal® Consta® (risperidone)  
 Vivitrol® (naltrexone IM)  Zyprexa® Relprev™ (olanzapine)  Other \_\_\_\_\_

Dose/Strength	Directions	Quantity	Refills

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_  
 PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Supervising Physician/Supervising Physician Signature \_\_\_\_\_

**Patient Authorization:** I authorize BrivoRx Specialty Pharmacy to bill my insurance company for this prescription and refills of this prescription. I understand that I am financially responsible for any co-pay/co-insurance amounts or other amounts not covered by my insurance. I understand that either I or my authorized representative will need to contact BrivoRx Specialty Pharmacy if there are changes in my insurance or I no longer need this prescription.

I authorize this prescription and all refills of this prescription to be shipped to my physicians office at the address below.

Physicians Name \_\_\_\_\_ Address 1 \_\_\_\_\_

Signature of patient or patient's authorized representative \_\_\_\_\_ Address 2 \_\_\_\_\_

**CONFIDENTIALITY STATEMENT:** This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

By signing below, I hereby authorize MedBox Specialty pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.