Prime Care Drug & Surgicals Corp.
SPECIALTY CARE

BEHAVIORAL HEALTH SPECIALTY CARE PROGRAM

Phone: **800-794-5565** • Fax: **844-525-6572**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY:

ICD-10: _____ ❑ Acute ❑ Chronic
Date of Diagnosis: _____ Contraindications: ❑ No ❑ Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
1.		
2.		
3.		

If Prior Authorization is Denied:
❑ Automatically Draft Appeal for Review ❑ Send Preferred Formulary Alternatives

Prior Failed Treatments:	Length of Treatment:

4 INJECTION TRAINING:
❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY:
❍ MD Authorize Delivery to Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION:
Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient DOB: _____ **Must Provide All Prescription Information**

Medication	Dosage & Strength	Direction	QTY	Refills
❑ ABILIFY MAINTENA®	❑ 300mg Lyophilized Powder ❑ 400mg Lyophilized Powder	❑ _____		
❑ ARISTADA®	❑ 441mg Prefilled Syringe ❑ 662mg Prefilled Syringe ❑ 882mg Prefilled Syringe	❑ _____		
❑ EVZIO®	❑ 2mg/0.4ml Autoinjector	❑ _____		
❑ INVEGA SUSTENNA®	❑ 39mg Prefilled Syringe ❑ 78mg Prefilled Syringe ❑ 117mg Prefilled Syringe ❑ 156mg Prefilled Syringe ❑ 234mg Prefilled Syringe	❑ _____		
❑ RISPERDAL CONSTA®	❑ 12.5mg Vial/Kit ❑ 25mg Vial/Kit ❑ 37.5mg Vial/Kit ❑ 50mg Vial/Kit	❑ _____		
❑ VIVITROL®	❑ 380mg Vial/Kit	❑ _____	1	11
❑ ZYPREXA® RELPREVV™	❑ 210mg Vial ❑ 300mg Vial ❑ 405mg Vial	❑ _____		
❑ _____	_____	_____		

PRESCRIBER SIGNATURE:
I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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