POLARIS SPECIALTY Rx

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Polaris Specialty Pharmacy
410 Cloverleaf Drive
Baldwin Park, CA 91706
NPI: 1053486795

MENTAL HEALTH INJECTABLE ORDER FORM

New Order or Refill: ☐ New Order ☐ Refill

Patient Information

Patient Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____

Alternate Contact Name: _____ Alt Contact Phone: _____

Gender: ☐ Male ☐ Female Allergies: _____ E-Mail: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Medical Justification

Diagnosis: _____

Tried and Failed History:

Medication (antipsychotic): _____ Date/Duration: _____

Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side effects ☐ Other: _____

Compliant Issue: ☐ Skipping ☐ Delayed ☐ Drug-drug interaction

Patient had injection site pain with oil-based conventional depot antipsychotic,

such as: _____ (medication name & dates)

Other: _____

Prescription Information

Medication	Strength	Directions	Quantity	Refills
☐ Abilify Maintena	☐ 300mg ☐ 400mg			
☐ Aristada Intio	☐ 675mg			
☐ Aristada	☐ 662mg ☐ 441mg ☐ 882mg ☐ 1064mg			
☐ Fluphenazine Decanoate	☐ 25mg/mL			
☐ Haldol Decanoate	☐ 50mg ☐ 100mg			
☐ Invega Hafyera	☐ 1092mg ☐ 1560mg			
☐ Invega Sustenna	☐ 39mg ☐ 117mg ☐ 78mg ☐ 156mg ☐ 234mg			
☐ Invega Trinza	☐ 273mg ☐ 546mg ☐ 410mg ☐ 819mg			
☐ Zyprexa Relprevv	☐ 210mg ☐ 300mg ☐ 405mg			

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____ E-Mail: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e-script.

I authorize Polaris Specialty Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ ☐ **Dispense as written (DAW) Date:** _____/_____/_____