OPTUMHealth™

Behavioral Solutions of California

Return completed form to:
Fax: 888-856-6873 or
Email: scott.ward@optum.com

Injectable Psychotropic Medication Enrollment 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® Relprevv™ (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 _____