

FAX TO: 1-800-459-2135

HEALTH INFORMATION DESIGNS, INC.
P.O. BOX 320506
Flowood, MS 39232
Phone: (800) 355-0486

**Brand-name Antipsychotic
Injections**
REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid #: _____

DOB: _____ City: _____
Month Day 4 Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____

City: _____ State: _____

NPI #: _____

Medicaid ID #: _____

Phone #: _____

Fax #: _____

Injectable antipsychotic medications are intended for administration in a clinic or hospital setting, rather than in the home. As the treating physician, I confirm that this drug is not stocked in my office for Medicaid beneficiaries or non-Medicaid patients. Further, I confirm that this drug will be delivered to my office by clinic or pharmacy personnel only for administration by a clinical staff member.

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Physician's Signature and date

PHARMACY INFORMATION

Dispensing Pharmacy: _____

City: _____ State: _____

Provider ID# _____

Phone #: _____

Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name and Strength: _____

NDC#: _____

Diagnosis: _____

Medical justification for injectable antipsychotic:

Is this patient receiving oral antipsychotic therapy? ___ Yes ___ No

If Yes, indicate the intended duration of oral antipsychotic therapy: _____

FOR HID USE ONLY

Eligibility Verified by _____

Approved _____ Denied/Code: _____

From Date _____ Thru Date _____

Reviewed by _____